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REPORT ON PRIMARY PREVENTION INITIATIVES IN CHILDREN'S SERVICES

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PART I:

CONCEPTS AND OVERVIEW

SECTION 1: INTRODUCTION

In 1978/79 the Ministry of Community and Social Services began promoting the development of prevention programs in children's services and, simultaneously, refining the ability to operate prevention programs effectively. This report, covering the work of the past five years, describes the prevention programs, research, training and public education activities. It analyses the collective experience in designing, operating and evaluating prevention programs, considers practical applications of the collective increased knowledge and suggests new criteria for prevention programs.

WHAT IS PREVENTION?

Prevention programs work to support families and children, in order to avoid problems that may cause suffering and require treatment services. Prevention promotes people's strength or competence while reducing stress in their living environment.

Prevention moves away from identified cases and toward populations and communities. Prevention programs avoid selecting individuals for intervention, preferring to intervene in the community or with a particular target group such as teen parents. This is to avoid stigmatizing or labelling particular individuals, to enhance the quality of life and family support in the whole community and to keep the unit cost of intervention as low as possible.

To use scarce resources most efficiently, prevention also emphasizes the concept of "populations at risk." Certain indicators (e.g., poverty, poor housing conditions, single parent households and minority group or immigrant status) are associated with a greater likelihood of developing emotional and social problems. Prevention programs use these indicators to help select the target groups and communities for intervention. The definition of prevention and the concept of "risk" are discussed further in Section 2.

WHAT HAS BEEN ACCOMPLISHED?

The prevention initiatives have succeeded in establishing prevention programs in different parts of the province. They have provided substantial experience in designing, operating and evaluating these programs. Experience indicates that a number of approaches to prevention are effective when correctly designed and managed, and that great care and substantial time are needed to plan and introduce a prevention program. Close supervision and evaluation are needed to select and refine the components of a program, and to maintain the focus of prevention.

In addition to the direct experience of the Ontario prevention programs, a large body of research literature helps identify the most promising approaches to preventive intervention. The relationship between stressful life events, or chronic life strain, and emotional and physical illness in adults and children has been substantially demonstrated. Social supports and coping skills have been found to protect people against the harmful impact of stressful events. Programs that enhance the social supports available to people or foster people's competence should help to prevent emotional and physical illness.

The results of the prevention projects confirm that programs can increase the social supports available to participants or enhance their feelings of support. Similarly, it is feasible to enhance competence through skill-development programs — parenting education, for example.

Section 3 of this report describes the activities that were planned in order to establish prevention programs and to increase practical experience in planning, operating and studying prevention. In Section 4 all the evaluated prevention projects are assessed. This is a review of the lessons learned about designing, managing and evaluating prevention programs of all types. From these conclusions emerge, in Section 5, new criteria for prevention programs, considerably more refined and specific than the criteria established in 1979 (which are in Section 3).

Part II of the report includes a more detailed review of prevention programs and research. Sections 6 to 12 comprise descriptions of seven different types of prevention programs and the results of testing these programs. The discussion of each intervention includes suggestions for future program development and study.

In addition to funding specific prevention projects, the Ministry supported prevention training, research and public education activities. Section 13 reports on these three areas and on the results, including training materials, a data base for prevention and other planning, and experience in public education about prevention.

SECTION 2: DEFINITIONS AND RATIONALE

BACKGROUND

This section includes a discussion of the definition of prevention, a brief review of recent contributions to the prevention literature and a discussion of "at risk" populations.

The State of the Art: A Background Paper on Prevention (1979:6), stated the case for prevention very simply:

> Although the species is in much better condition than it was a mere hundred years ago, it appears that, even in this affluent society, a large number of children and their parents are not well 'tended'. Over the years more and more studies have emphasized the extent of emotional and behavioural dysfunction in children...It is becoming clearer that our palliative social, health care, and correctional methods, while effective for many children, have failed the children who are most 'at risk'. The developmental potential of these children has been wasted, the cost to society is enormous, and their future competence as parents is in jeopardy. For that reason, the search for protective factors and feasible preventive measures (individual, familial, environmental and societal) is becoming more urgent.

There appears to be widespread agreement that it is preferable to avert problems now rather than solve them later. Despite this, treatment and rehabilitation services continue to command greater attention and a larger proportion of government funds than prevention. Because corrective services are so highly visible, and results of preventive programs are neither obvious nor easily measured, the public demand for treatment and rehabilitation is understandable. However, curative services are tremendously costly, not only in dollars but also in the psychological and social trauma associated with disability for families and for society.

What is necessary is promotion and enhancement of skills within families and supplemental organizations, such as the school. This will not only encourage individual competence but prevent problems. In other words, services that support children and families, teach them ways of coping with stress and encourage self-responsibility for all aspects of health are preventive in nature.

DEFINITIONS

Prevention consists of concentrating on particular groups of families and children within the whole population and trying to promote their optimal development and to reduce the incidence of handicaps, disorders and dysfunctions, whether mental, physical or emotional. Three main kinds of prevention have been identified.

1. Primary prevention aims at reducing the incidence of new cases in a population. It refers to activities, of both proved and presumed efficacy, that are intended to prevent certain disorders and dysfunctions. Its two different aspects are (a) efforts that concentrate on modifying the stressful environment, i.e., specific protection; and (b) strengthening the ability of the individual to cope with stress, i.e., promoting health or competence.

2. Secondary prevention aims at reducing the prevalence (number of existing cases) of a disorder or dysfunction. It includes early identification and active treatment.

3. Tertiary prevention (or rehabilitation) aims at reducing the after effects or sequelae of disorders or dysfunctions.

For the purposes of constructing a consistent approach to prevention policy, using three definitions is often confusing. In this report, as in the work of the past few years, the terms "prevention" and "primary prevention" are used interchangeably. It is clearer to assign one meaning to the term prevention (i.e., reducing the incidence of new cases in a population), and to call other programs treatment and rehabilitation, than to call all services some form of prevention.

Types of Prevention Programs

Three main types of primary prevention programs may be identified:

1. Community-wide programs, in which the target group consists of everyone living in a specific area. Mental health education efforts by the mass media illustrate this approach.

2. Milestone programs, in which all residents of a particular community are screened at a specific time, e.g., at birth, on starting school or on entering high school.

3. High-risk programs, in which groups especially vulnerable to specific stresses or outcomes are identified, and programs are designed to decrease or prevent the occurrence of those stresses. One example of such a group is socially disadvantaged children, i.e., with more than four children in the family, with a single

parent, living in poverty or living in poor housing. Other examples are children of schizophrenics or alcoholics and children who have been subjected to large numbers of life changes in a short time.

The Efficacy Of Prevention

As a first step in planning prevention policy in Ontario, a major review of the concepts and efficacy of prevention was prepared. This report, The State of the Art: A Background Paper in Prevention, discussed a wide range of preventive activities and the evidence available about them. Preventive interventions were identified at each stage of children's lives, including:

- prior to conception and during pregnancy
- the perinatal period
- infancy
- preschool years
- elementary school years
- adolescence.

Evidence presented in the State of the Art was used, in many instances, to develop proposals for prevention programs to be tested.

In the meanwhile, evidence about the need for prevention and ways to enhance the growth and potential of children has continued to emerge in the relevant literature. The research sponsored by MCSS in the past few years has included a review of literature pertinent to primary prevention. Several major areas are reported here.

RECENT STUDIES OF PREVENTION

Prevention of Child Abuse and Neglect

A comprehensive review of literature on the prevention of child abuse and neglect (Helfer, 1981) concludes that "prevention of many forms of child abuse and neglect is achievable if, and only if, the approach is multifaceted." As outlined by Helfer (1981, p. 259), the interventions and approaches must include some combinations of the following:

1. a community consortium committed to the dictum that family violence in their community is unacceptable;

2. a mass media, never-ending campaign to educate the public on this dictum;

3. ...some form of training for all new parents in the art of communicating with one's new baby;

4. a home health visitor program for all new parents for the one to two years after the birth of their first born child;

5. an early child development program for all preschool children run by churches, schools, community colleges or whomever;

6. an interpersonal skills program (how-to-get-along curriculum) in the public schools built upon simple skills in grade school, advancing to courses in sexuality and parenting in high school; and

7. an adult education program for two levels of young adults — those who had a positive rearing and want a refresher course in childhood before they become parents; and those whose childhood was very minimal who need a "crash course in childhood" before parenting is undertaken.

Prevention of Mental Retardation

Prevention of Intellectual Handicaps (Fotheringham, Hambley and Haddad-Curan, 1983) is a recent and comprehensive review of the conditions affecting children's potential to learn and to achieve self-sufficiency. The state of current knowledge about causes and prevention of intellectual handicap covers the following areas:

- maternal lifestyle during pregnancy, including nutrition, use of drugs and alcohol, and smoking

- the social environment, including poverty, the learning environment, family and pre-school influences, adolescent parents and child abuse

- environmental agents, including poisoning, accidents, pollution and radiation

- inherited factors in intelligence, including chromosome disorders, genetic disorders and central nervous system disorders.

This study includes an estimate of the amount of mental retardation that could be prevented by strenuously applying current knowledge. The estimates involved studies of two samples of retarded persons, born 20 to 30 years ago. If the preventive programs available today had been applied 20 to 30 years ago, handicapping conditions would have been eliminated in 9 percent of the study sample. However, if current knowledge had been applied systematically, the handicap could have been prevented in about 23 percent of the group.

Family Support

The relevance of social support or family support in the theory and practice of prevention is becoming more clear. Several recent examples are described below.

A study titled The Nature and Effectiveness of Family Support Measures in Child Welfare (prepared for the Ministry of Community and Social Services by the Canadian Sociotelic Society) includes a discussion of the theory and function of support services for families. The types of family support identified include:

- o concrete or tangible supports, such as homemakers, budget counselling
- o educational and coping skills development, such as parent education
- o information life skills, such as advice on legal rights
- o social integration, such as network development, self-help groups
- o emotional support, such as counselling
- o directive support, such as case-work, respite care
- o environmental action, such as single parents' associations, advocacy.

The report describes and assesses a range of formal and informal family support programs identified in the literature, and presents useful information for program design.

The effectiveness of social support in protecting people against the effects of stress has been reviewed as part of the evaluation of the Highland-Stirling Neighbourhood project (see Section 11). Cohen and Turner (1983) demonstrate the association between low social support, low self-esteem and life stress, and elevated levels of depression in the study population. They note that numerous studies have reported associations between psychiatric distress and disorders and such factors as low socio-economic status, social isolation and minority group status. One of the most promising explanations of different susceptibilities to psychiatric distress lies in the lack of social relationships or support that is characteristic of these factors.

In a similar vein, the evaluation of the Jane Finch Community and Family Centre (Hodgson, 1983) found that the family resource centre did help participants' networks of friends to expand. The new relationships were helpful in reducing participants' unmet needs, and

they came to feel that they were not unusual in the amount of stress they faced. Equivalent levels of stress resulted in fewer instances of depression among participants than the control population. In addition, the program helped participants become involved in other community organizations and take on special responsibility significantly more frequently than did the control group.

Prevention for Infants "At Risk"

Interventions in support of infants who are at risk of not achieving their normal development have also been studied recently. Over 40 infant development programs are operated in Ontario by public health units, hospitals, associations for the mentally retarded and other sponsors. A Survey of Infant Stimulation Programs in Ontario (1982, prepared by A.R.A. Consultants for the Ministry of Community and Social Services) indicates the programs are primarily an assessment and home visiting service for parents whose children have developmental disabilities, and/or are at risk because of home conditions (e.g., immature caregivers, alcoholic parents, low-I.Q. parents).

A follow-up study was done with infants who had received program services over a period of several years. The study showed that infants who were discharged from programs as "rehabilitated" or because workers had decided they had improved sufficiently were consistently associated with higher change scores on a standardized measure. The Bayley Scales of Infant Development had been administered to the infants as an initial assessment and at program termination. It was found that the program helped infants at risk to achieve developmental norms appropriate for their age.

Summary/Reflections

The effort to increase the state of knowledge about ways to protect the health and well-being of children and families reveals many practical approaches and possible interventions. Primary prevention is not restricted to a few interventions but requires concerted and co-operative efforts among services, organizations and society as a whole. Prevention involves not only social services, but collaboration among health services, schools, social services and community voluntary organizations.

Prevention includes a range of programs, from public education to alter attitudes (e.g., about child abuse), to life skills training, adequate nutrition and emotional support. While some preventive interventions, such as genetic screening, are highly technical, many are conducive to a self-help model, as illustrated by work in social support and peer counselling.

This brief review of the literature illustrates that our knowledge is expanding, as we test and modify research hypotheses and study actual programs. Given the scope of possible preventive endeavours, choices will need to be made constantly among alternative needs and programs. These choices are assisted by continued refinement of our knowledge and skills in prevention.

THE CONCEPT OF "AT RISK" POPULATIONS

Like prevention, the concept of risk is borrowed from the public health field and the study of patterns of illness. The term "at risk" implies an increased probability of handicapping conditions, disabilities or dysfunctions in a given population. For example, women over age 35 are known to be at greater risk than younger women for complications of pregnancy and delivery leading to handicapping conditions. We also know that children may experience cumulative risk as the number of factors associated with vulnerability (such as large family, parental instability or criminability, poor nutrition) increases. This means these children are more likely to experience emotional, social and physical health problems than are other children without these background factors. It is said that two so-called risk factors places a child at four times the risk of a child experiencing only one such factor.

To determine where groups of children are likely to be at increased risk, it is necessary to turn to broad community variables. Social indicators are a useful tool for assessing an area or community, relative to other areas or communities, to determine where children are more likely to experience problems, though not which children. There is a tendency for problems and the factors associated with them to cluster. Poverty and low socio-economic status, for example, tend to be associated with a whole range of social and physical health problems, and variables that reflect this aspect of life quality are therefore useful as indicator variables.

Examples of social indicators that are useful to determine where children risk social, emotional and physical health problems are listed below.

<u>Socio-economic measures</u>

- Proportion of low-income individuals
- Rate of renter-occupied to owner-occupied dwellings
- Dependency rate — children in families receiving FBA
- Single-parent family rate
- Large families
- Educational attainment
- School drop-out rate — grades 9 to 12
- Immigration rate — living in Canada less than five years
- Mother tongue not English.

Social Pathology

- o Out-of-wedlock birth rate
- o Rate of births to teen mothers
- o Alcoholism rate — hospital discharges for alcoholism
- o Alcohol psychosis rate — hospital discharges for alcohol psychosis
- o Suicide rate
- o Violent crime rate
- o Juvenile crime rate
- o Unemployment rate.

Physical Health

- o Premature birth rate — live births under 2,501 grams
- o Perinatal mortality rate - infant deaths occurring between the 28th week of gestation and the first 7 days after birth
- o Infant mortality — infant deaths under one year
- o Immunization rate (Diptheria, Pertussis, Tetanus, and Polio)
- o Tuberculosis rate — indicates resistance to communicable disease.

These variables may be useful as a planning tool to determine where problems will most likely occur in the child population relative to other areas or communities, and to give some general sense of the types of problems people experience.

In the sections describing prevention programs, data have been collected on some of these dimensions. These data are pertinent to assessing whether prevention programs are reaching vulnerable families and children.

SECTION 3: METHODOLOGY

INTRODUCTION

In 1978, the Ministry decided, in keeping with efforts to increase the effectiveness of its children's services system, to designate prevention programs as a priority area for research and development.

Prevention programs were defined as those programs striving to reduce the number of new cases in a population. Preventive approaches are intended to reduce the need for high-cost treatment services, and thus help control increases in social service expenditures, by modifying a stressful environment or strengthening people's ability to cope with stress.

Prevention programs help reduce the suffering people experience when problems become acute. In addition, they allow individuals and families to avoid the stigmatizing effects of some social services, while facilitating access to treatment and rehabilitative services when needed.

The key issues in prevention were recognized to be:

- reaching populations at risk of serious problems and
- problems associated with the actual organization, funding and delivery of prevention programs.

It was recognized that a comprehensive strategy was necessary to deal with these issues, and to develop a Ministry role and presence in prevention. To do so, it was necessary to advance the state of the art in prevention, to begin to change services and budget allocations, to encourage collaboration among service providers and service systems, and to educate professionals and communities about prevention. Accordingly, a set of six strategies was adopted by the Ministry:

- review of existing literature and preparation of a plan of activities and research to support and learn about preventive approaches
- selection of test programs (program assessment awards) to evaluate the effectiveness of selected prevention programs
- provision of matching grants for agency-sponsored programs (supplemental awards) to encourage the gradual shift of a percentage of current expenditures into prevention activities

- o selection and funding of an epidemiology unit to provide the Ministry with research data leading to more effective planning and provision of prevention and other programs

- o planning and provision of prevention promotion and training programs to inform, assist and train individuals and organizations to accept greater responsibility for prevention and to demonstrate government leadership in prevention

- o co-ordination of efforts between MCSS and other ministries to encourage co-operative approaches to prevention and joint or multiple Ministry prevention projects.

Activities in all the prevention initiatives are described below.

IMPLEMENTATION

Review of Literature and Implementation Plan

The results of the literature review were published in a document entitled The State of the Art: A Background Paper on Prevention. The paper contains a comprehensive review of knowledge concerning the theory and practice of prevention, as discussed in Section 1.

A second document, Toward a Prevention Policy, described the various ways in which the Ministry planned to support and monitor preventive approaches, so that the Ministry's role vis-a-vis these programs could be decided. The implementation plan, which was a part of this document, specified activities for the five-year period 1979/80 to 1983/84.

Research and Development Programs

The research and development projects were called program assessment awards, and were designed to test and evaluate different types of prevention programs. Proposals were requested from agencies and community organizations, and a final selection was made based on criteria contained in guidelines that were published and distributed in the Fall of 1979. Over 70 proposals were received and were reviewed by head office staff, regional office staff and consultants.

The criteria used to select program assessment awards are in Table 3.1. The eight proposals approved for funding are described in Table 3.2. (Both tables appear at the end of this section, pages 15 and 16).

Each program required an initial planning phase, which included negotiating contracts and budget with Ministry staff. During the

planning phase, each project hired an evaluator to test the program's effectiveness. Selection of each evaluator was approved by the Ministry. The start-up phase took most projects about twelve months, which was longer than had been originally anticipated, thus shortening the duration of the evaluation.

One project was terminated because the small number of participants made evaluation impossible; the remaining seven are still in operation and an evaluation report is available for each. The projects are described in Sections 6 through 12.

Agency-Sponsored Programs

Supplemental awards were planned as an incentive for agencies to reassign a portion of their budget to preventive programs, preferably in co-operation with other agencies or community groups. The Ministry offered a matching grant (50/50) to agencies on the understanding that at the end of the two-year demonstration period, where program results were positive, the Ministry grant would become part of the agency's base budget. No formal evaluation was conducted, but information about projects is available through progress reports and reports from program supervisors.

Eighteen supplemental awards were approved for funding in 1980/81 and seventeen were funded in 1981/82. They are described in Appendix 1, (page 88) which lists prevention projects in each region of Ontario.

Epidemiology Unit

An epidemiology unit was established at McMaster University and was given the responsibility of developing a solid data base to help improve planning and delivery of Ministry programs, including prevention. It has conducted a major community survey to determine the prevalence of emotional and behavioural problems in children and adolescents in Ontario, related to various socio-demographic and service characteristics. All the data have been collected and are being analyzed; a final report will be available later in 1984. The work of the unit is described in Section 13.

Promotion and Training Programs

In addition to funding individual prevention programs, the Ministry wished to emphasize the importance of preventive approaches through education of the general public and through training of agency staff.

A major campaign, the Positive Parenting Program, was mounted; it consisted of a series of pamphlets and TV spots on parenting techniques. A test study conducted in London in 1980/81 showed that television is an effective way of reaching many families with a supportive message.

The Ministry provided funds to two agencies with experience in training in the development of prevention programs to conduct workshops across the province. Training sessions are now completed, and one agency continues to provide follow-up consultation to agencies and Ministry staff as required. The Ministry also funded a small conference on prevention in June 1982, and another in November 1983. These activities are described in Section 13.

Inter-Ministerial Co-ordination

An inter-ministerial task force on prevention operated for six months. Its mandate was to review legislation, funding procedures and prevention programs funded by the Ministries of Community and Social Services, Culture and Recreation, and Education and Health. In addition, the committee examined how social indicators might be used to determine the extent to which children in various parts of the province are more vulnerable to developing social or emotional problems.

MCSS staff and Ministry of Health staff have co-ordinated efforts in the prevention of handicaps. As one co-operative initiative, MCSS transferred funds to the Ministry of Health to extend genetic screening services in Toronto, Hamilton, London and Ottawa. It is expected that further co-operation will occur in such matters as rubella immunization and pre-natal health.

Summary

Through a co-ordinated set of strategies, including program funding and evaluation, training, public education and research, the Ministry has worked toward a more substantial understanding of prevention programs and a more practical knowledge of how to develop and operate prevention. The results of these strategies and practical outcomes are reported in the following sections.

TABLE 3.1 CRITERIA FOR SELECTION OF PREVENTION PROGRAM ASSESSMENT AWARDS

Program Criteria

1. Projects that demonstrate that research, theory and knowledge can have a substantial impact on preventing problems.

2. Projects that clearly document the high-risk population groups or communities to be affected.

3. Projects that can be developed for large populations.

4. Projects that include inter-agency joint efforts at the community level (e.g., children's services, health, education and recreation).

5. Projects that involve voluntary and community groups.

6. Projects that encourage self-help and self-care.

Organizational Criteria

1. A clearly defined sponsoring organization should be responsible for the development, operation and evaluation of the project.

2. The organization should demonstrate a high level of community co-ordination and inter-agency planning.

3. The organization should demonstrate a capacity to manage a project of that sophistication and duration.

4. The project should be administered in such a way that funds can be easily channelled from the Ministry to the project and proper auditing can be carried out as necessary.

TABLE 3.2 OVERVIEW OF PREVENTION "PROGRAM ASSESSMENT" PROJECTS

Project Title	Type of Sponsor	Location	Target Population	Intervention Types
Reseau Parent Networks, Ottawa	Three existing community organizations	Low-income neighbourhoods	Mothers with young children in subsidized housing; anglophone & francophone parents	Drop-in centres, respite care, parenting education
Community Clinics, Sudbury area	Regional mental health centre	Northern rural & small towns; "boom" town	Parents with young children; anglophone, francophone, & native parents; teenagers	Parenting education, drop-ins, peer counselling; youth skill development and recreation
Highland Sterling Neighbourhood Project, Kitchener	Children's mental health centre	Low-income, highly transient, urban neighbourhood	Families and children, especially low-income	Activity & skill development groups; local board development; problem solving for school children; parenting education
Child Care Networks, North York	Faculty of Social Work, University of Toronto	Densely populated neighbourhoods, low-income, subsidized housing	Working & at-home mothers with young children	Creation of child-care & personal support
Montrose Infant Care Centre, Toronto	Board of Education	Urban, primary school near three secondary schools	Teen mothers & infants	Infant day care, parenting skills & counselling for mothers

Northeast Neighbourhood Centre, North York	Children's mental health centre	Suburban, subsidized housing	Families; day care and school teachers and children; other professionals	Drop-in centre; home support program; parenting education; school and day-care consultation
Caribbean Outreach Project, North York	Community organization	Densely populated, low-income	Immigrant families	Crisis intervention; family life education; recreation/ skill groups for children and teens; school enrichment
Stay Healthy Early, Peterborough (Discontinued)	New organization, local board	Small urban	Pregnant teenagers	Co-ordination of support services, counselling

SECTION 4: THE DESIGN, MANAGEMENT AND EVALUATION OF PREVENTION PROGRAMS

Specific prevention programs and types of intervention are discussed in Sections 6 to 12. In addition to outcomes specific to each prevention program, the prevention projects as a whole have contributed to an improved understanding of delivering and evaluating prevention programs. This section discusses the overall results of the prevention projects in the areas of program design, management and evaluation. The items discussed in general terms here are based on the actual operation of prevention projects. The useful results include practical lessons about prerequisites for program design, operation, management and evaluation on which to base future efforts in primary prevention. Experience in these areas can be translated into practical guidelines for future prevention activities.

PREVENTION PROGRAM DESIGN

Program design is the process of describing in detail the method of delivering a service or program to meet certain goals. The program design should state the rationale, target population, approaches/intervention modes, organization and anticipated benefits.

Rationale for a prevention program

A rationale or justification for a particular program design must address both the actual need or interest in a community and the available research evidence about a particular type of intervention. The selection criteria for prevention projects (discussed in Section 3) emphasized reference to the relevant literature, which often contained the findings of research studies in other jurisdictions. This remains an important consideration as research evidence accumulates to indicate appropriate points or styles of intervention.

It is equally important to establish a clear need for a given project in the proposed catchment area or target population. A theoretically sound project may founder for lack of participants needing or wanting the service. For example, a prevention project for pregnant teenagers was well designed as a program, but could not engage sufficient participants to make a valid research effort feasible, because of small numbers of potential participants and problems in reaching them. If the potential target population is very small, sample size becomes a central consideration in program design.

Project Goals and Target Population

Project goals should be clearly stated, in order to organize strategies and select priorities. The project's goals must also reflect community priorities or needs as stated above. An assessment of need leading to identification of a specific target population permits design of a program tailored specifically for local people and circumstances.

Clear goals for the project as a whole and its components contribute to effective project management. But effective management is only useful insofar as the project is meeting expressed community needs.

Defining the "community" or in fact the target population has been difficult in several instances. There is agreement about criteria of "high risk," including low income, poor housing and overcrowding, unemployment, single-parenthood, racial discrimination and so on. The application of the criteria is clear when the target is, for example, pregnant teens or teen mothers. It is less clear when the target is a whole community, and not every member can, or wishes to, participate. The problem then becomes refining the definition of target population within the community and ascertaining the actual needs of that target group. Needs analysis processes that engage the community itself in defining need and establishing priorities will bring the proposal closer to a practical definition.

When community need (or target population need) and project design are a good "fit," the result can be enhanced community involvement, a feeling of ownership about the project and local commitment to it. Examples include youth programs where community leaders welcome and support the service, and parent-child drop-ins that are heavily used — to the extent of waiting lists.

Sponsorship

The sponsoring organization takes responsibility for program operations. The prevention projects have had a variety of sponsors, including established children's mental health centres, children's aid societies, community associations and organizations, school boards and public health units. This eclectic approach to sponsorship takes advantage of the interest and commitment of different groups and individuals to prevention. It recognizes the need for flexibility, the strength of interdisciplinary activities and the unique configuration of resources in each area.

Certain standards are essential to utilize the range of potential sponsors. Sponsors must have experience in prevention and/or a strong commitment to prevention. There needs to be agreement about what prevention actually means in practice. The sponsor also needs an understanding of and commitment to the target population.

A good "image" in the community is necessary. A prevention program sponsor needs to have good and credible working arrangements or linkages with other community agencies and organizations, in particular in relation to the target population. For example, an effective working arrangement with a local tenants' association may be as important as links with a treatment agency.

Approaches to prevention must be non-coercive; prevention programs are voluntary. Prevention attempts to reduce the stigmatizing effects of social services. This issue is particularly critical for agencies whose services are perceived commonly as stigmatizing and coercive. Great caution and care are needed to avoid turning program participants into clients. Geographic location away from the sponsoring agency may be essential if a treatment agency wishes to engage in prevention.

The distinction between primary and secondary prevention may be a fine line in practice, especially when participants experience a range of needs and problems and when agencies deliver a variety of services. Sponsoring organizations face the challenge of providing programs that are supportive and enhance strengths without slipping into a treatment model.

A sponsor needs to provide a strong back-up role (including access to professional services) for front-line prevention staff who are paraprofessionals. For example, prevention projects have had to train workers about child abuse procedures and resources for referral. In addition, working with highly stressed participants or in a community with many needs is very wearing on staff. Sponsors need to provide emotional support, especially to paraprofessional staff. One excellent approach to this problem involved a professional volunteer in regular meetings with paraprofessional staff, for advice and support.

Sound administrative capability is necessary. As noted above, it is sometimes necessary to devise a "trade-off" between organizational strength and community involvement. Since both are necessary, greater assistance may be needed to develop administrative capacity in the sponsoring organization. However, this needs to become a requirement, not just a suggestion.

Joint Sponsorship

Several prevention programs have experimented with joint sponsorship. When there is clear agreement about program goals and strategies, joint sponsorship is an effective means of pooling scarce resources (human and financial) to develop a program.

However, maintaining co-operation among several sponsoring groups may be very time consuming and even counter-productive. A project with components in different neighbourhoods, committed to meeting participant needs in those neighbourhoods, may have real difficulty maintaining common policies and directions.

Expectations, responsibilities and commitments of resources and staff need to be negotiated and clearly stated, and even contracted among the sponsors. It will be necessary in future to explore carefully the terms and conditions of joint sponsorship, to help resolve issues between the groups, and to renegotiate arrangements if necessary. The strategy of joint sponsorship remains attractive in order to pool scarce resources and use them effectively. Caution and flexibility are necessary in establishing these arrangements.

Program Activities and Strategies

Program activities and strategies logically flow from the program goals and community needs. Clear description of project content or strategies is also necessary. In retrospect, descriptions of prevention program activities were often vague, and it was unclear just who would do what with whom, how often and for what purpose. It was sometimes difficult to link the proposed program activities to specific project goals or community needs. There needs to be a balance between experimentation with different program components and consistent planning of program activities.

Clarity should not be confused with lack of flexibility to change program strategies and even goals if necessary in response to changes in, or more accurate perceptions of, community or participant needs. Evaluation can be an aid to checking whether a program is reaching its target population or achieving its goal, and whether a program must go "back to the drawing board."

It is useful, as well, to link project activities to specific priorities in the needs of the target population. This enhances a program's flexibility and its potential to consider alternative approaches if the preferred approach or program does not work or is not acceptable to the community.

The physical setting of a project and its activities is important. The project needs to be accessible — both physically and psychologically — to the target community. This includes walking distance, public transportation routes, cheerful surroundings, and an accepting, non-threatening environment.

Outreach Strategies

Outreach strategies aim at obtaining co-operation and participation in a program. The strategies to be used need to be built in to project design. Considerable thought needs to be given to reaching the target population in sufficient numbers. Most prevention program proposals did not describe in detail how they might communicate the existence of

their program to potential participants. This is an especially important point since prevention programs involve people who do not necessarily have any "felt need," and who are not generally referred to a program. This is a substantial difference between a prevention program as opposed to a treatment program. In the latter case, people might be expected to recognize that they should seek some kind of assistance or service.

Further, participants in prevention programs have often been socially isolated, they may have experienced services of traditional agencies and they are often lacking in confidence. Potential participants need to be sought out, informed and invited. Outreach to people who are isolated, depressed and perhaps fearful requires persistent effort and considerable time and skills.

Outreach is a difficult area requiring skills not present in all staff. It was an area of weakness in several of the prevention projects (or project components), and is an area where training is needed.

Links with Other Programs

Linkages with other programs — whether treatment or prevention — are essential to prevention program design and delivery, and were recognized in the selection criteria for prevention projects. When an existing agency sponsors a prevention project, links with other agency programs and interagency groups may be acquired naturally. When the prevention project is sponsored by a community group — especially a newly formed community group — the linkages with other community agencies for co-operation and referral require special attention. Such a prevention program will need to be able to refer participants for other services when necessary. Other services will recommend that their clients participate in the prevention program. For example, a local children's aid society may encourage parents to use a parent-child drop-in program. Realistic expectations on both sides need to be discussed and agreed to.

MANAGING PREVENTION PROGRAMS

Management of prevention programs concerns both program sponsors and staff, and responsible MCSS managers. The rubric "program management" covers starting projects, staffing, job descriptions, in-service training, budgeting, reporting requirements and supervision. In general, knowledge about sensible program management applies to prevention services as to any other. This section reviews only those areas most pertinent to prevention programs.

Start-up Phase

The nature of a prevention program is, generally, that it enables participants to do things for themselves, to learn new skills and to develop new networks and supports. Participants need to experience a sense of program ownership and control, to be part of selecting alternative program components. For these reasons, prevention project starts are often slow, and there may be some "false starts."

It is also necessary to assume setbacks, and even the failure of projects or program components. Reviewing these negative experiences is important for learning how better to design and implement prevention, and for improving the approach to community involvement and co-operation. Indeed, this is one purpose of the current review of projects. In many instances, a pilot project phase might be an appropriate start for a project, before substantial resources are committed.

Project design must recognize the probability of slow starts, and must include an implementation plan with a start-up schedule. Project proposals seldom describe in any detail the schedule for detailed program design, or for the selection, recruitment and training of staff. This type of schedule would be extremely valuable since many of the people responsible for managing prevention programs have had limited management and program start-up experience.

Staff Selection and Training

As noted above, community involvement is essential to the functioning of a prevention program. Prevention projects appear to function most effectively with staff selected from the catchment area or local community, staff who are particularly aware of community needs and the sources of stress in people's lives. The drawback is that these staff may lack experience and training, including training in management and administrative skills, in outreach techniques and in program planning. In the prevention projects, staff selection was sometimes done on a casual basis, through friends, rather than by a systematic search process. Only a few projects addressed the training needs of paraprofessional staff in a planned and deliberate way. The basic procedures of orienting professional staff to the philosophy, policies and objectives of the program were sometimes neglected. Professionals were assumed to "know what they were doing," an attitude that does not recognize the attitudinal changes that are fundamental to moving from treatment services to prevention.

Project sponsors need to consider carefully whether professionals can staff a prevention project as effectively and efficiently as paraprofessionals. Perhaps a combination of staff backgrounds is necessary, depending on project purpose and scale. Job descriptions would aid staff selection processes.

Staff Supervision

Program management concerns include the roles of staff and their day-to-day supervision. About half the projects had job descriptions and included staff performance reviews. In others, there were few job descriptions or performance standards and, as a consequence, some confusion over responsibilities, roles and reporting relationships of staff. Staff often assumed they were hired simply to deliver a service, not recognizing that a major part of the job was outreach and facilitation of participants' efforts.

An essential component of prevention program management is developing and reviewing job descriptions and supervising staff. It is often necessary to identify areas for staff development and training. The area of staff supervision is suitable for future training efforts in prevention.

Within the projects, reporting relationships were sometimes a problem; e.g., board to director, director to staff. This type of problem may arise particularly with projects sponsored by community groups, but is not limited to such organizations. Clarity is required in the determination of roles and expectations. It may be necessary to provide consultation or closer Ministry supervision for some of these arrangements.

There is a tendency in prevention programs to emphasize that each particular situation is unique, and that staff approach their work in very individual fashion. This is most likely to occur in instances where program design has not been specified clearly and where program accomplishments are not monitored regularly.

Resource Allocation and Reporting Requirements

Fiscal restraint has been the norm for prevention projects. Because of this constraint, and the need to watch expenditures very closely, total budgets were set very firmly, but treated flexibly between categories of expenditure.

This flexibility led to budgets being presented in very broad terms. In retrospect, it is difficult to assess the division of funds between program components and between types of responsibility. For example, it is not always clear, in practical terms, how much staff time has been spent on planning and preparation, services and administration, and what portion of a budget is devoted to these activities.

Improved reporting and budgeting systems are needed for prevention projects and should become part of the Ministry's contract with the project. Design of future programs will need to establish more precise information, control and reporting expectations for each project. A balance needs to be maintained between avoiding excessive "paper work" and enforcing basic reporting requirements.

Ministry Role in Project Supervision

During the research and development phase of prevention programs, Ministry supervision has been generally restricted to project monitoring and efforts to help resolve specific problems as they arise. A more systematic approach to reporting and monitoring of prevention programs needs to be designed for on-going program supervision. Design criteria and conditions for funding should include the Ministry's supervisory mandate.

There is still much to learn about the successful operation of prevention programs. Part of the Ministry responsibility is to identify program strengths and weaknesses and to transmit new information about prevention programs to other interested groups and agencies. Given the need for smooth prevention program operation, close supervision is also necessary until program staff have acquired sufficient management and administrative skills, and until program components are well in place.

EVALUATING PREVENTION PROGRAMS

An enormous literature is already available on program evaluation. However, the experience of evaluating prevention projects to date indicates areas where particular problems arise and where further developmental work is needed. Some aspects of prevention project evaluation are amenable to better planning and management, and some problems require further study and new techniques.

Defining and Measuring Outcome

The project evaluations focussed both on the process of project implementation and on the effectiveness or outcomes of each project. This meant that project objectives had to be defined in measurable terms, and that data collection was designed during the start-up phase. While it is a difficult process for many projects, the exercise of setting clear objectives and relating these to program components and staff functions is a useful planning technique and should be a prerequisite of prevention program funding. Evaluability assessment is a practical tool in prevention program design and management; a program that is not evaluable by accepted objective methods will probably have little chance of achieving its goals.

Finding ways to measure prevention outcomes entailed experimenting with different study designs, measurement instruments and approaches to analysis. The evaluation studies have helped to indicate promising approaches for future studies.

Prevention programs are meant to reduce the incidence of new social, emotional or physical health problems, requiring treatment, in specific target groups or communities. However, the percentage of really vulnerable people within a population is typically very small. Therefore, it is difficult to identify supporting evidence for a change in the incidence of a wide range of different types of problem in the proportion of the "at risk" population who are actually likely to experience such problems. Strong research designs are necessary.

The evaluation study designs generally called for comparison groups, and a great deal of effort went into trying to locate appropriate comparison populations or communities. However, in the end few of the projects found adequate comparison groups. Projects utilized a combination of pre-test, post-test measures, waiting list participants and heavy/light users, as well as selected groups for comparison purposes. Further work is needed to identify appropriate unobtrusive ways of comparing program impact in similar communities.

Assessment of prevention programs can include measures of individuals and of communities. Individual measures include program participation, satisfaction and individual change. Community measures are indicators of large-scale group or population changes. One basic measure of program impact is simply whether people in the target group choose to attend it. When, for example, a program is considered to be primarily recreational, whether or not people attend may be simply a matter of preference. In prevention programs the intent is not strictly recreational; it is to develop skills, enhance support and improve self-esteem, often in people who are very isolated and unaccustomed to group participation. Acceptance and use of the program becomes a useful measurement of its effect. One general objective of testing prevention programs was to learn about ways of actually reaching designated target groups.

Another means of assessing program effect is consumer satisfaction. In almost every case, respondents indicated the extent to which they "liked the program." Information was collected, in various ways, on the types of information or satisfaction they gained from attending the program.

Such direct and common-sense questions are useful as long as the possible sources of bias are recognized. That is, a parent might say that she learned a lot about her child as a result of attending the program. Other peoples' observations of how she handles the child, or an objective test assessing factual knowledge about child development, may show that the parent did not in fact actually learn anything or did not change. Nonetheless, in the absence of direct observational data or data collected by means of a valid and reliable instrument to assess knowledge of child development, the response on a common-sense question about "perceived" learning is better than nothing.

Measuring Individual and Community Change

Objectives for prevention projects tend to anticipate outcomes at both a community and an individual level. To date, measurement of community change attributable to a prevention project is feasible mainly by assessing program "spin-offs" and activities generated by the project in the community and by means of data on vandalism rates, fire calls, school performance and other unobtrusive measures. These are substantial results of prevention interventions. Further work is needed on approaches to documenting and measuring such change.

Some individual change outcomes may be measured by established instruments. But the nature of participation in the programs means there may not be a great deal of room for movement on standardized tests or scales. Most tests are designed for clinical populations and are being administered to a cross-section of community residents, not a clinical group. This implies that little change can be registered on standard measures. As well, program participants are sometimes reluctant to complete evaluation questions on very personal information.

Research into preventive health is still relatively new and there is a significant absence of tests that are standardized and normed on the populations being studied. When a program appears to have no effect, or minimal effects, it is difficult to know whether the problem is in the adequacy of the program or in the lack of sensitivity or accuracy of the measuring devices. Further work is needed to identify the most sensitive and appropriate standard measures relevant to prevention programs.

Program participants may have a wide range of needs and may be offered a number of programs. However, the tests required to assess all manner of possible benefits take so much time that one would lose the participants' co-operation. Of course, participant co-operation depends in part upon the co-operation of program staff, and this is often a problem in collecting data.

As noted, further developmental work is needed in the techniques and design of prevention program evaluation. In order to advance the field, replication of certain studies is warranted. Prevention program evaluation needs consistent use of appropriate, existing standardized instruments, in conjunction with careful design of new instruments, open-ended interview techniques and observational approaches to assessing program effects.

Program Staff Co-operation

Some tension is natural between program staff and evaluator; the evaluation process is not necessarily welcomed, even when it is a condition of funding. In these projects, great care was taken to select experienced and qualified evaluators. However, evaluation designs typically require assistance from program co-ordinators and staff. Problems arise when staff function very independently or are not given adequate instructions in the reasons for, and procedures of, the evaluation process. When this occurs, data collection or communication to participants about the evaluation procedures may be poorly handled.

In managing evaluation processes, it is necessary to provide adequate training for program staff, to monitor data collection and to institute adequate quality control procedures. As evaluation should continue to be integral to prevention programming, staff training in this area will need further attention.

Prevention Program Evaluation in Perspective

A specific outcome study cannot be the sole basis on which to judge prevention programs. Whether a program is successful or not depends, of course, on factors other than just the results of research. First and foremost, there has to be some evidence that the program reached the population intended. Thus, there should be some minimal data, such as documents and program reviews, that show that a program actually was delivered as promised and reached the target group. An evaluation study may also show how a given program should be re-designed, or may indicate that a lengthy period of involving the community and assessing need is prerequisite to program implementation.

Apparent Validity

The problems in measuring effectiveness range from the adequacy of measurement devices to the wide range of variability in the ways in which people are likely to be affected by a program. Most treatment programs are in existence, not because they have demonstrated effectiveness, but because experts in the area, as well as people receiving the service, are prepared to take the program at face value

and accept its validity. It may be argued that prevention programs should not be subjected to a "double standard" of proof. However, continued evaluation of prevention is important to increase our knowledge about what approaches are most effective. Prevention is a new area of social service expenditure requiring proof of relevance and effectiveness before becoming an established program. New interventions need to be tested carefully before they are expanded or replicated.

Conclusions

Experience with the prevention projects has been very useful as an input to criteria or guidelines as to how the future design, management and evaluation of such programs should be handled. Detailed information about program implementation and effects is available simply because this was an evaluation study rather than a more arm's-length program funded by the Ministry. The process of program design and operation is as important to accomplishing the goals and objectives of prevention as the outcomes. Prevention needs comprehensive evaluation.

It should not be surprising that when a group attempts to design and market a new product (e.g., prevention programs), there are some failures. Even in the commercial world, where there is careful emphasis upon testing an idea for acceptability before making a commitment to offer it to the public, there are still frequent failures. The prevention projects had several "products" that did not sell.

Sometimes the problem was the product; sometimes it was the management or the delivery of that product. Intelligent efforts were made to balance the objects of maintaining consistency for research purposes, and adjusting the products — within limits — to be more appealing to the target group. The fact that out of all the programs offered there were only a few failures in attendance and satisfaction is remarkable. Also, a lot was learned about this process. Few of the project managers, staff or evaluators would not now be able to improve upon the means of designing and marketing their existing programs, not to mention their ability to make correct decisions about stopping some activities while initiating others. Sometimes the improvement would be to the program; sometimes the improvement would be to the management of that program; but a consensus on what is needed in each case could be more easily derived.

The approach to evaluating prevention has assessed what projects are trying to accomplish as well as what they are trying to prevent. This practise needs to continue. It is necessary to explore spin-offs in the community as well as to measure change in program participants. As with management of prevention projects, their evaluation requires a

more "hands-on" approach in the initial learning stages. Finally, given the slow start-up of prevention program and numerous program and evaluation design issues, it is useful to do process evaluations prior to outcomes evaluations, as a matter of practice.

SECTION 5: CRITERIA FOR THE DESIGN, OPERATION AND EVALUATION OF PREVENTION PROGRAMS

Section 4 of this report was a discussion of general issues in designing, managing and evaluating prevention programs. In Part II, to follow, Sections 6 to 12 contain descriptions and assessment of various approaches to prevention, including comments on the replication of each program type. Section 5 presents suggested criteria for designing, operating and evaluating prevention programs, which use the results to give greater direction to the future implementation and study of prevention programs.

In short, we have advanced the practical aspects of implementing prevention programs. This advance is reflected by the contrast between the guidelines published in 1979 with the initial call for prevention proposals, and the criteria suggested here.

Likely it would not be possible for a program to meet all these criteria. There are always trade-offs between breaking new ground, for example, and planning every program detail in advance; between smooth administration and the flexibility to alter a program in response to community needs. Nonetheless, the evidence suggests that clarity (for example, clear intent and job roles) is important to establishing an alternative approach to services. It is increasingly necessary to be aware of where compromises are being made, and to aim at meeting the criteria suggested here.

DESIGN CRITERIA

Assessment of Need:

1. The program aims to meet needs as perceived by the community and/or target population.

2. These needs are deemed to be "real" by both program sponsor and funding body.

3. If these needs are not met, the consequences in people's lives are serious.

4. The target group is clearly identified, both as an "at risk" population and in sufficient numbers.

Intervention:

1. There is scientific evidence that the proposed intervention can meet the needs identified.

   Levels of evidence include, in order of strength

   - o results of randomized control studies
   - o results of pre-test, post-test studies or time- series studies
   - o review of available program descriptions.

2. The objectives of the intervention are clearly stated and measurable.

3. The intervention:

   - o provides or enhances social support
   - o enhances competence or coping skills.

4. The intervention includes:

   - o parent-child resource centre, drop-in program
   - o skill development
   - o parenting education
   - o community resource development
   - o support for teen mothers.

5. Program costs are low overall and on a unit basis.

Program Components:

1. There are clearly defined program components and alternatives. (Preferably, keep number of components to a minimum in the beginning.)

2. The program components relate to assessment of needs and objectives.

3. An outreach strategy is clearly identified and described. Alternative strategies are suggested.

4. The program setting is physically and psychologically accessible to the target group.

Program Phases:

1. A specific start-up phase has been planned.

2. A plan exists to phase out the program if necessary.

SPONSORSHIP CRITERIA

1. The sponsoring organization has experience with prevention and/or management of a community service program.

2. Resources are available to administer and account for program funds.

3. The sponsoring organization's experience indicates competence, flexibility and ability to work with a community.

4. If joint sponsorship is proposed, the organizations have agreed to their respective roles and a process for resolving problems.

Community Links:

1. The sponsor has appropriate links with other community services for a co-operative, non-duplicative program.

2. The sponsor can attract other community resources to contribute to the prevention program.

3. The sponsor participates in an inter-agency council, prevention committee or similar group.

4. If there is a local voluntary advisory group it has been involved in planning the prevention program.

Governance:

1. The sponsor has a board of directors, and it has approved the prevention program.

2. The board includes community residents and/or members of the target group.

3. There is a clear reporting relationship between prevention program and board.

4. If there is an advisory group to the prevention program, the members are experienced local residents.

Administrative Arrangements:

1. The sponsor has designated an experienced administrator for the prevention program.

2. Resources (consultative, back-up help) are available to this administrator.

3. There are adequate arrangements for bookkeeping and clerical support.

OPERATIONAL CRITERIA

Funding:

1. The program requires only seed or start-up funding. Other funding sources are clearly defined.

2. The sponsor has explored other possible sources of funds.

3. The sponsoring agency is prepared to contribute all or part of the project funding from its existing budget.

4. Budget guidelines have been met.

5. The budget is reasonable for program components.

Staffing:

1. Numbers and qualifications of staff are adequate for program needs.

2. Job descriptions have been clearly defined.

3. There is a plan for orienting staff to the prevention program.

4. There is a clear and open process for selecting staff, including designating who is involved in the selection process.

5. Staff training needs are identified and planned for.

6. There is an appropriate balance of professional and para-professional staff.

Volunteers:

1. If volunteers are to be used, plans exist for how they will be recruited and trained.

2. A staff person has been designated as volunteer co-ordinator.

Staff Supervision:

1. Staff supervision is a planned program function, and responsibility for staff supervision is assigned to a specific person.

2. The program co-ordinator/administrator has supervisory experience, or is prepared to undertake in-service training.

3. Training is available in managing supervisory responsibilities.

Reporting:

1. Reporting relationships among program staff, sponsoring organization and board are clearly defined.

2. There is a system for periodic (at least quarterly) program reports to sponsor and Ministry.

Planning:

1. Program planning is a clear program function.

2. An appropriate person (usually the co-ordinator) has been given responsibility for program planning.

3. A group has been designated to review and approve program plans, according to a schedule.

EVALUATION

Understanding:

1. The sponsoring organization accepts evaluation as a condition of funding.

2. The sponsoring organization is prepared to devote staff time to evaluation.

3. A pilot phase has been designated and clearly agreed upon.

Evaluator for Process Evaluation:

1. The program has identified a local researcher to help with process evaluation on the program, especially during the start-up phase.

2. This research has made clear a commitment to the program.

Data Collection:

1. The start-up phase includes design of data-collection instruments.

2. The start-up phase includes staff training in completion of necessary data collection procedures.

3. There are sources of unobtrusive data to evaluate program outcomes.

Feedback:

1. There is a schedule for reviewing program results.

2. The organization is prepared to accept evaluation of program outcomes.

PART II:

PREVENTION PROGRAMS

PART II: PREVENTION PROGRAMS: DESCRIPTION AND ASSESSMENT

A number of prevention projects, termed "program assessment awards," were funded and studied intensively during 1980 to 1983 to test different approaches to prevention in terms of target, program components, staffing, location and so on, and to illustrate the problems associated with designing, operating and evaluating such programs. As reported in Section 3, over 70 project proposals were received and screened, and eight were eventually selected as test projects. Seven projects have been evaluated, and this part, sections 6-12, reports on these programs.

An overview sheet for each project, with information on its sponsor, objectives, target population, program components, staffing, evaluation design and measures, is contained in Appendix 2. Most projects in fact include several different program components or types of intervention. The sections that follow are an analysis of seven different types of program, with brief descriptions of actual program and experience operating and evaluating each. The types of prevention program are:

- parent education programs
- parent-child drop-in programs
- skill development for children and teens
- programs for teen mothers
- community development and networking
- school-based programs
- home visiting.

A section is devoted to each type of program intervention and includes:

- description of programs and evaluation
- evaluation results
- assessment of results and planning for the future.

These sections are largely based on the evaluation studies and program reports of each project, and on project review and Ministry staff supervision. Both process and outcome information have been collected. Information on some of the supplemental projects is also included; this too is drawn from progress reports and studies. Pertinent questions include:

- o did the program move from concept to implementation as envisaged?
- o did the program reach and engage the target population?
- o did the program have a demonstrable (measurable) effect on participants?
- o were there spin-offs that affected the larger community?

The reports of results here are brief and include only measurable outcomes that were statistically significant at the 0.05 percent level or approached this criterion of significance. For a discussion of levels of significance and interpreting research findings, see Appendix 3.

SECTION 6: PARENT EDUCATION PROGRAMS

Parent education programs are designed to help people deal more effectively with their children's behaviour. More specifically, such programs help parents understand what behaviours can be expected from children at certain stages of development, and how, in concrete terms, they might deal with child-rearing issues (e.g., parent-child communication, discipline, child's need for independence vs. parental need to protect, etc.). Following is a brief description of parent education programs provided by two program assessment awards, and the results of their evaluation.

RURAL PRIMARY PREVENTION PROJECT

Description

Four parenting programs were conducted by the Sudbury project. Two (locations: Elliot Lake and Manitoulin Island) were directed at anglophones, one (location: Elliot Lake) was directed at francophones, and one (location: communities near Espanola) was directed at the native population. Staff were locally recruited paraprofessionals. The English program in Elliot Lake had an earlier start up than the other three programs. The STEP (Systematic Training for Effective Parenting) program was modified for the local program and was offered thirteen times in nine-week sessions. The parenting program directed toward anglophones on Manitoulin Island started later than its counterpart in Elliot Lake, and had more trouble attracting participants. This was due in part to the different demographic characteristics of the two areas, Manitoulin being characterized by a scattered, rural population of only 7,000 non-natives, in contrast to the more concentrated population of Elliot Lake. Eventually four parenting programs were organized in different communities around the Island.

The program directed towards francophones in Elliot Lake started later than the one directed toward anglophones because French course materials were not available. English STEP materials were translated into French by program staff, and adapted to increase their relevance to the francophone population. A total of five sessions were held.

The program directed toward native persons in the Espanola area was operated quite differently from the preceding three. It consisted of a series of topical workshops, with a number of sessions devoted to traditional child-rearing and parenting issues. Initially the intent was to run a parenting program that would be similar to the first three described; it was soon realized by program staff that culturally

appropriate program materials were not available. Therefore considerable energy was devoted to development of suitable program materials and delivery stategies. This culminated in the development and delivery of sessions on topics of concern to the native population (e.g., Parent and Child—Victims of Abuse, Alcohol and the Family, Discipline and Child Management). Each workshop was delivered in each of three northshore communities, and attendance totalled eighty. Attendance varied among topics, ranging from a low of 12 to a high of 24.

Results

Seventy parents participated in the English program in Elliot Lake and the effect of the program was measured using the following instruments:

- o a questionnaire, with a fifteen-point checklist measuring quality of parent-child interaction
- o a series of vignettes requiring the parent to write their response to the hypothetical situation described.

Each test was administered before and after the parent had participated in the program. In most cases, the post-test was administered in the participant's home several weeks after the program ended. Each participant also completed a program satisfaction questionnaire. In addition, spouses of married participants were asked to report on the participant's behaviour, using the same instruments in addition to an open-ended question concerning the changes they observed in their spouse. Finally, a control group (n=5) composed of parents on a waiting list to take the program also completed the same instruments. Evaluation of the Manitoulin programs was similar to that of the Elliot Lake program, although no control group was used. Because of the perceived likelihood that participants would be reluctant to fill out questionnaires, the instruments used in Elliot Lake were modified for Manitoulin and were returned directly to the evaluators, to preserve anonymity. The study sample totalled 20 parents.

The evaluation of francophone program was conducted identically to that of the anglophone program in Elliot Lake, except that questionnaires were translated into French and administered in French (sample 42, control group 6). Evaluation of the program for native people was by means of a participant satisfaction questionnaire.

The program directed at anglophones in Elliot Lake showed the following results:

On the fifteen-item questionnaire, positive change occurred in all fifteen items, with change occurring at a statistically significant level in twelve of the fifteen. The largest positive changes reported

occurred in the following items: losing one's temper less often, sending child to room less often after running into a problem, talking things over when a problem is encountered, spanking child less often after running into a problem.

The control group, in contrast, showed no clear pattern of movement between the pre-program test and the later test. Some items remained unchanged, and where change was reported it was both positive and negative. Responses to vignettes were significantly more positive after program participation, in that they reflected an increased tendency for the parent to respond to a problem by opening parent-child communication rather than by using immediate negative sanctions (e.g., scolding, punishment). The accounts of spouses of participants supported the participants' own account of how they would deal with the situation described in the vignette.

The program directed at anglophones on Manitoulin Island showed the following results:

Effects of the program, as seen in shifts of scores between the pre-program test and the post-program test, were positive on fourteen items; the shifts, however, were of a modest size and only in the case of one item does the shift reach statistical significance. The results were weaker than those of the Elliot Lake program for anglophones but seem to indicate consistently that positive although modest changes had occurred. Smaller sample size may partially explain these smaller gains.

The program directed at francophones in Elliot Lake showed the following results:

Changes occurred in a positive direction on twelve of the fifteen items after participation in the program; few of these changes, however, reached levels of statistical significance. In contrast to the positive direction shown by the experimental group, the comparison group registered negative shifts in eight of the fifteen items, the remainder being positive or stationary.

In response to the vignettes, results were similar to those achieved in the program directed towards anglophones in Elliot Lake; following the program, participants showed a greater tendency to select responses permitting parent-child communication about the incident rather than using immediate sanctions with no recourse. Those results were verified by responses of participants' spouses.

The program directed at native persons in the Espanola area showed the following results:

Participants reported that the program components were informative, met their needs as parents, and improved their understanding of the session topics. As well, they reported wanting additional information

and workshops on selected areas. Outcome (i.e., behaviour change before and after the program) was not measured; in terms of client satisfaction, however, this program clearly met the expressed needs of the targetted group.

In addition to the quantifiable results described here, the program has produced useful parent education materials for the different groups of parents. Spin-off effects include, on Manitoulin, development of parent-child drop-ins, other self-help groups, a "storytime" program for native children and a mobile toy lending library, which visits at least seventeen small communities on the island. In Elliot Lake the spin-offs include development of a francophone day-care centre, co-operative work among community groups to establish a crisis centre, an inter-agency group and programs for teens and preschoolers. Other native communities and associated groups have requested that the parenting material be made available to their resource people.

CARIBBEAN OUTREACH PROGRAM (COP)

Description

Nearly all adults served by COP, including the family life program, were born in the Caribbean or West Indies (92%). They had lived in Canada five years or more (82%), although 17% had lived in Canada less than five years. Many were recent residents in the community: up to two years (21%) and two to five years (53%). The participants had also moved within the neighbourhood: within the past year (19%), one to two years (14%), two to five years (47%). Half the participants had attended some or all elementary school; 27% had some high school and 10% had completed high school. Only 25% were employed full time; fully 50% were unemployed and 16% had part-time jobs. Almost half were single parents, and parent-child separations were experienced within 75% of families (44% for longer than a year).

The COP provided a lifeskills and effective parenting program (Family Life Education Program), which staff developed in an attempt to meet the needs of the West Indian community, especially new immigrants to Canada living in North York. It included components that are standard in most parent education courses, such as active listening and interactive feedback, as well as health education and discussion of common parenting problems with special reference to the problems encountered by Caribbean families. Each course consisted of eight or ten weekly sessions, each two to three hours long. The sessions, conducted in small groups, took place in community centres or, less frequently, in private homes.

During the course of the project, the program content was reviewed and simplified, and the program was shortened from ten to eight weeks. Twelve groups were held during the twenty-one-month evaluation period. A total of eighty-one people attended at least one group regularly (i.e., were present at half or more of the sessions), and about 160 attended at least a single session. Group size ranged from three to fifteen; usually there were four to five people in a group. Attracting and retaining participants was an on-going difficulty.

Results

The evaluation used a pre-test and post-test approach, occurring at the second group session and the end of the series respectively. The following instruments were used:

- o parent's assessment of child (using the Adlerian Parental Assessment of Child Behaviour Scale as a source of items)
- o health information quiz (consisting of factual matters discussed in the course)
- o parenting styles questionnaire (developed for this program, presenting a pair of parental behaviours, one positive and one negative, for reaction by participants)
- o participant satisfaction questionnaire.

Difficulties were encountered in creating a control group. Originally a control group was to have included friends and neighbours of participants; this proved unsuccessful and a control group was selected by program staff. Multiple sessions with this group proved impractical, therefore it provided a point comparison with the experimental group, but not a comparison over time.

In terms of participant satisfaction, 89% of people stated that they were very glad to have been in the program, and 11% said they were somewhat glad to have participated. Eighty-eight percent said they would recommend the program to others. Forty-eight percent felt their behaviour had changed a lot, and the same percentage felt it had changed somewhat.

In considering the effect on their children, 24% of participants felt they had observed a lot of positive behaviour change in their child, 48% had observed some and 28% had observed little or none. Twenty-three percent saw very positive change in the parent-child relationship, 58% saw some positive change and 16% saw little or none. Four percent had observed negative change. In the parental assessment of children, using the behaviour described earlier, some positive changes were seen, but these were weak and only approached statistical significance. Nor did

the difference between the comparison group and the experimental group reach statistical significance.

Differences on the parenting style scale were in the predicted direction but not statistically significant. Pre-test to post-test change on the health information quiz did reach significance.

OTHER PARENTING PROGRAMS

In addition to programs described here, several other projects had parenting education components. In the Highland-Stirling Project, parenting education was one part of a series of community programs. Over time, leadership of parenting groups was assumed by community residents.

In the Northeast Neighbourhood Centre, staff provided a series of workshops and seminars for local professionals and parents on parenting and child care. Parents found the sessions very relevant and rated the programs highly.

A prevention/outreach project sponsored by the Sarnia Lambton Centre included weekly parenting groups as a program base; it also encouraged use of other community resources, sponsored a family supper club and facilitated parent self-help groups.

RESULTS OF EXPERIENCE - DIRECTIONS FOR THE FUTURE

Planning a Parent Education Program

A major concern for parenting education programs is to define the intended target group. It is still not clear which parents are attracted to these programs, and what concerns they bring. Demographics must be carefully considered. If the target group (parents with children under 18) is geographically dispersed, an eight-week course held at one central location will not attract sufficient participants. A geographically mobile program should therefore be planned, offering shorter courses in several communities. The ages of families and children need to be taken into account. If culturally or geographically appropriate course materials are not available, these should be developed during the planning phase. Materials seen as irrelevant by participants will affect participation negatively. The program needs to adapt to the concerns and learning styles of participants.

Delivering a Parent Education Program

There should be sufficient flexibility to change program design and content according to needs of participants. The Caribbean Outreach Program found, for example, that a ten-week session was longer than desired by participants, and therefore shortened courses to eight weeks; content was made less academic and more concrete.

To attract participants, outreach is necessary. Word of mouth will attract some, but in the case of COP, for example, less than five percent of parents had heard about the Family Life Education Program from a friend. Outreach should be directed toward community residents at risk, since risk factors (stress, isolation) are often associated with parenting problems.

Staff are key to the success of a parent education program. They should be experienced and able to strike a rapport with participants. Preferably they should come from the same socio-economic background as participants. There is potential for volunteer leadership in these programs as well, which needs to be addressed in prevention training activities.

A lecture format seems to be less effective than a discussion format in retaining information. The latter allows parents to learn from one another's experiences and to model their behaviour accordingly, which is an important principle of prevention programs.

Programs should be provided in a neutral, non-threatening environment (e.g., a community centre rather than a social agency). Parents may feel that choosing to attend such programs reflects inadequate parenting practices and proximity to a child-treatment service may build on such feelings.

Evaluating Parent Education Programs

It appears that these programs do have some measurable impact on participants, but not necessarily a dramatic one. One reason may be many parents attending the courses are already motivated to be good parents, and therefore score well on pre-program tests. This limits room for change or improvement during the program. One aspect of evaluating a parent education program should be to document which parents in the target population do, in fact, participate.

It is clearly possible to measure differences in parents' willingness to talk with children and to try different ways to solve parent-child problems. It seems easier to prove retention of information than to prove attitudinal changes. Nor has it been demonstrated whether these programs will substantially affect behaviour in the short term or the long term. Longitudinal studies would be needed before such conclusions can be reached.

Participant satisfaction tests clearly show that parent education programs meet parental needs, as reaction was generally favourable in each program. An unanswered question is whether community residents who have not participated in courses may benefit indirectly (by example or modelling) from the improved parenting skills of program participants.

To conduct a rigorous evaluation it is, of couse, preferable to have random assignment to a control or comparison group. All parent education programs had trouble recruiting such a group, even when monetary incentives were offered. In planning the evaluation, it should be decided either to devote considerable time and effort to this element of the evaluation, or to dispense with it entirely and simply use pre-test, post-test measures.

Outcomes other than attitudinal changes in participants should be included as part of the evaluation. If new culturally appropriate course materials are developed, for example, as occurred in the native program in Espanola and the francophone program in Elliot Lake, these constitute spin-off results of the intervention.

SECTION 7: PARENT-CHILD DROP-IN PROGRAMS

Parent-child drop-in programs provide an opportunity for informal family support, parenting education, child stimulation and mutual support among participants. A variety of program elements may be present in the drop-in: structured child stimulation; unstructured play; respite care (the child stays, the parent has free time); structured and unstructured discussions of child development, parenting and other topics such as nutrition; and informal counselling and referral. The program assessment projects included several examples of parent-child drop-in programs.

RESEAU PARENTS NETWORKS (RPN)

Description

The RPN project was sponsored by three organizations: the Parent Preschool Resource Centre, the Pinecrest Queensway Community Services Centre and the Centre de Resources de la Basse Ville. The Parent Preschool Resource Centre (PPRC), which operates drop-ins for English and French-speaking families, provided outreach and helped local groups with program planning, material and consultation. The PPRC was the administrative base and program resource for the project. The two community service centres co-sponsored the project in different targetted neighbourhoods. Both Pinecrest-Queensway Community Services Centre and Centre de Resources de la Basse Ville housed project staff and assisted with local planning and resources. The three organizations co-operated on ongoing direction for the project.

The project aimed to reach low-income families living in subsidized housing or in neighbourhoods characterized by transiency and relocation. The intent was to improve parents' abilities to deal with stress in family life, to enhance their relationships with their children, to improve parents' own self-image and to encourage better use of existing community resources.

RPN comprised five neighbourhood drop-in programs: four (Pinecrest-Queensway) were directed at anglophone families and one (Basse-Ville) was directed at francophone families. The staff were mostly paraprofessionals selected from the local community.

The four Pinecrest-Queensway drop-in programs were located in, or adjacent to, rent-geared-to-income housing. They facilitated children's activities, parent discussions and informal modelling of good parenting practice.

Outreach to locate parents, inform them of the program and reinforce attendance at drop-ins was integral to the program; the process was repeated throughout the project time span.

To supplement the drop-in programs, a "parent support" worker was part of the project. "Parent support" activities included developing self-help groups in six rent-geared-to-income housing areas, working with tenant councils, and individual counselling, especially with very socially isolated people. Over time, the parent support worker became co-ordinator of the drop-in programs and worked with a parents' committee and with self-help groups (e.g., committee on abused women). The drop-ins were seen as the basic program activity, with other parent support activities arising from the groups or introducing people to the groups.

Total participation was 136 parents and 219 children in the first year, 132 parents in the second year and 117 parents in the third year when the largest program separated into two groups (only one of which was part of this study). Approximately half the parents attended regularly (at least twice a month). The portion of parents registered who dropped out of the program during a year ranged from a high of 60 percent to a low of 21 percent. Follow-up with parents who had left the program attributed turnover primarily to "outgrowing" the program, finding employment and moving from the neighbourhood. Participants left one program because it was too popular and had become over-crowded.

The drop-in and parent support program in Basse-Ville developed quite differently. A central locale was selected and the initial workplan emphasized community development and consciousness-raising rather than parent support. During the first year, project staff convinced the city to purchase an empty building, which was converted into a parent-child drop-in. Outreach was attempted briefly in the second year, but resulted in few new members. A parents' committee was also established and began to take a role in program planning and in advocating for a local day care centre. The program included a drop-in, parent discussion groups and respite care.

There were 69 parents participating in the second year and 43 parents in the third year. Approximately 40 percent attended regularly (defined by staff as at least once every two months). Turnover reflected brief participation and returning to work. The most active component was the parent committee, which had greater participation than other ongoing activities.

Program staff were mostly paraprofessionals. Co-ordination and supervision were provided by trained staff; however. program participants were hired as staff after the program had been functioning for some time.

A third program component to the PRN project was provided by PPRC outreach workers who were a resource staff to the local drop-ins and who worked with other interested groups to establish loosely affiliated, voluntary parent-support groups. The number of such groups grew from five in 1978 to 79 in 1983.

Results

Evaluation assessed the process of developing and operating parent-child drop-ins, organizational issues raised by co-operative sponsorship, and the program effects of the drop-ins, by means of:

- a parent interview/questionnaire administered to participants at five intervals, (depending on length of involvement, parents were interviewed up to five times)
- staff diaries
- participant observation during the first six months
- case studies and program documents.

Socio-demographic data show that the Pinecrest-Queensway programs were able to attract and involve a target group of low-income, sole-support mothers. In a sample of 96 mothers, participants were largely under 30 years old (72%), had high school education or less (76%), had lived in the neighbourhood two years or less (66%), did not have relatives in the area (66%), were single parents (31%) and had "below poverty line" incomes (63%).

A survey of the Pinecrest-Queensway neighbourhoods served by the drop-ins showed that 39% of local residents with pre-school children were participating in the programs.

Participants (n=32) in the Basse-Ville program were in their thirties (53%), had education levels beyond high school (53%), had incomes "above poverty line" (61%) and were two-parent families (84%). Most (75%) had lived in the area for two years or less, and 62% did not have relatives in the area. A review of census data for the catchment area revealed a fairly high ratio of single-parent families (20%). Rental accommodation predominates. It is not known what portion of francophone families had preschool children. The program attracted the francophone population, but generally not a low-income group.

A total of 404 interviews were conducted: 126 participants were interviewed once, 60 were interviewed twice and 44 were interviewed three or more times. The flexible nature of drop-in programs makes following individual participants especially complicated. Interview data were supplemented by case studies, staff diaries and participant observation.

Of the study sample, nearly 30% were new residents in the neighbourhoods, and only 15% had resided there more than five years. Two-thirds did not have relatives in the area, and 28% were single-parent families. Half of the families had incomes below $25,000 per year, including 39% with incomes below $9,000.

Participants rated the programs highly and attributed to the program greater understanding of their children (69%) and improved relationships with their children (70%). Low-income parents were significantly more positive about program attendance as a way of making new friends, and as a way of becoming more involved in their community. Participants perceived the program as a source of social support and encouragement to mothers.

Analysis of information about specific parents indicates a number of instances of participants keeping children who were clearly candidates for foster care, and incidents of wife abuse averted. These examples are not "statistically significant", but are illustrations of new treatment cases avoided.

NORTHEAST NEIGHBOURHOOD CENTRE (NNC)

Description

The Northeast Neighbourhood Centre serves a new suburban area characterized by a large number of children, single parents, social disruption, isolation, poverty, high-density living and other indicators of family stress and risk to children. The project aimed to reach families through several program components.

One component of the Northeast Neighbourhood Centre program involved two parent-child drop-ins, one located in a public school and the other in a rent-geared-to-income housing complex. The drop-ins aimed to provide stimulation for children, to increase parents' ability to stimulate children, and to facilitate mutual support among participants. The drop-in program was voluntary, but once involved, parents were required to abide by program policies and staff expectations. The drop-in program was structured to encourage both child stimulation and parent interaction and discussion.

High levels of participation led to overcrowding in the school drop-in. Interested parents eventually had to make appointments to attend the drop-in; most spaces were for long-time users and those recommended by staff due to involvement in another component of the NNC program. A total of 79 families were involved in this drop-in, with 41 attending regularly (10 times or more), 17 occasionally (3 to 9 times) and 21 rarely (1 to 2 times). The smaller drop-in involved 14 families with 6 regular participants; 153 children were involved in both.

Results

The drop-ins were evaluated by means of two surveys of participants. Participants in the larger drop-in located in the school (n=60) were aged 22-33 (81%), were married (76%) and had husbands employed in business, professions, trades and services (total 68%). The second drop-in had fewer participants. Reaching the low-income population remained a problem.

In one survey, parents (n=40) felt the program was beneficial for their children, and provided relief and information for parents. In another (n=67), the majority of respondents felt they had received the kind of service they wanted, were satisfied with the amount of help received, and would recommend the program to a friend. Overall, parents found the program to be excellent and stimulating for their children and themselves. A few questioned the staff's assumption of authority over participating parents or being treated as if they were in a treatment program.

RESULTS OF EXPERIENCE — DIRECTIONS FOR THE FUTURE

Designing Parent-Child Drop-In Programs

Location is important. The program must be physically accessible to parents with young children. A location near other community programs (or an integrated setting) helps drop-in participants learn about other programs, use them and begin to contribute to various activities. Environment/atmosphere is equally important; a drop-in needs to be psychologically accessible, welcoming and a comfortable place for children and parents.

Program design needs to include: resources for planning program content; training of drop-in staff about treatment services and referral; emotional support for paraprofessional staff; and outreach as a specific function.

Previous community development work, and a local agency or community organization committed to child and family needs, help shorten the start-up phase and strengthen program delivery.

Parents from a variety of backgrounds, economic statuses and languages are interested in drop-in programs. As a mode of social support, it is attractive to the parents of young children.

Delivering Drop-in Programs

There needs to be flexibility to respond to parent needs as they are expressed and change. The Pinecrest-Queensway program developed both active drop-ins and other spin-offs as it responded to parent concerns.

Staff must understand the life experience of participants, and must treat participants not as clients, but as neighbours and friends. Programs with high participation rates tend to use paraprofessional staff selected from the local community. These staff will need back-up resources for planning, referral and their own development on the job.

Outreach needs to be an integral component of the drop-in program. Outreach should be directed toward community residents who are more isolated and experience greater chronic stress.

Drop-ins should facilitate problem-solving and mutual support among participants, not dependence on the drop-in staff. This is a fine balance for staff to maintain.

Evaluating Drop-in Programs

Continuous turnover among participants is a major problem in evaluating drop-in programs. However, turnover does not necessarily indicate failure as long as the target group is being reached. If successful, programs help parents to move on to other groups and activities. As well, the programs appeal to parents of preschool children; as children enter school the parents turn to other work or activities.

An unanswered question is the extent to which this type of program involving informal parent education affects actual parenting behaviour.

Evaluation design should include a number of dimensions to capture the different effects of a drop-in program. There are effects on individual participants; there are spin-off programs; and there are changes in group behaviour.

SECTION 8: SKILL DEVELOPMENT FOR CHILDREN AND TEENS

Skill development programs provide recreation, job-related activities and group counselling and discussions. These activities aim at enhancing self-esteem and increasing the range of useful skills of participants, including job-related skills, athletic and recreational skills and inter-personal competence. One prevention project operated programs for youth in Massey (a northern town) and on Manitoulin Island (a sparsely populated rural area). The Caribbean Outreach Project operated several youth groups for West Indian immigrants in a densely populated urban setting. This section also discusses a skill development project in Ottawa that is described in Offord and Jones (1983) and was funded by Fitness and Amateur Sport Canada, the Hospital for Sick Children Foundation and the Ontario Ministry of Culture and Recreation.

RURAL PRIMARY PREVENTION PROJECT

Description

On Manitoulin, most of the youth-related activity centred in the island's only secondary school. The school not only provided the best access to the young people; it was also the focus for parental concern about the need to bus children long distances each day. The project worked to establish the legitimacy of a youth program and to develop suitable activities. Efforts to involve youth in programs evolved in several phases:

- initiation of youth groups in three communities; subsequent discontinuation in two of these because of scarce staff resources
- sponsorship and supervision of summer youth-employment projects (three summers)
- establishment of "running" club for native and non-native youth
- initiation of a peer counselling program in secondary school, which was discontinued with staff turnover and subsequently re-established by community request.

In contrast, the concept of a youth program had existed intermittently over forty years in the Massey Teen Town. The prevention project aimed to establish the program on a secure and continuous basis. The activities of the youth program included group discussions, town clean-up, community health day and recreational activities.

Staff included locally recruited paraprofessionals and community development workers.

Results

The Manitoulin youth program was not formally evaluated on outcome measures, due to slow program development, changing activities and staff changes.

Evaluation of the Massey youth program was by means of:

- a rating scale (entry, mid-point and post-test) administered independently by program staff, with checks for inter-rater reliability; intervals were eight months and six months
- surveys of community leaders and of parents (usually mothers) of program participants
- survey of participants and non-participants.

Evaluation of the Massey youth program collected rating scale data on a total of 61 participants. Over time, program drop-outs reduced the comparison numbers for each interval (n=21, 24 and 17 for the respective intervals). The most significant changes in social skills occurred where the earliest and last ratings were compared; 12 of 16 items showed significant differences. Items included self-confidence, assertiveness, problem-solving, decision-making, working in a group, responsibility and organizational skills. In the other intervals, a smaller number of significant changes occurred. Rated on an overall three-point risk score (low, medium, high), the participants also showed change in the appropriate direction, but the changes did not reach significance.

The absence of a comparison group makes it difficult to attribute these changes to the program alone (rather than, for example, to maturation). However, interviews with parents confirmed the impression that the program had positively affected the youth. In interviews, attitudes of community leaders to the program also tended to be positive.

Of the 61 young people involved, approximately 17 participated during the whole period the program was being evaluated. The remainder participated for shorter intervals. It is not clear what portion of the town's youth population this represents.

The effect of the Massey youth program can also be assessed by the fact that it has served as an example to neighbouring communities, which are attempting to establish such a program.

For the Manitoulin youth program, only informal indications of program impact are available. These include:

- o entry to a closed, rural community appears to have been accomplished
- o community demand that the peer counselling program be re-established in the local secondary school, after the project had discontinued the program
- o summer employment opportunities for some youth, in three consecutive years
- o leadership training provided for some youth
- o support from professional community to keep youth worker.

CARIBBEAN OUTREACH PROGRAM

Description

The youth component of the Caribbean Outreach Program aimed to involve recently immigrated young people who were adjusting to family and community life in Canada. This program consisted of several groups of teens and pre-teens, who met once a week for sports and recreation, life-skills education and informal counselling. The groups were structured as to age and sex: there was a junior girls' group, a senior girls' group, a junior boys' group and a senior boys' group. Staff were locally recruited paraprofessionals and volunteers. Examples of activities in which the groups were involved are:

- o informal discussions concerning relationships with parents, career preparation, sexuality, nutrition
- o leadership exercises
- o assertiveness and self-awareness exercises
- o recreational activities (e.g., dance, table tennis)
- o films (recreational and educational).

Results

Evaluation was by means of questionnaires distributed to participants and their parents. For one program, the senior girls' group, a social support index was administered with a six-week interval.

In all, the programs included 67 teens and 84 pre-teens. Efforts to attract participants to the program included door-knocking, advertising and flyers. Attendance for these groups were variable: in 1981-82 there were 85 participants and in 1982-83 there were 66 participants. Participants' opinions (n=40) of the program were fairly positive, with 27% of participants rating it as "excellent" and 30% rating it "very good." Parents were also positive in their feelings concerning the program, with 20% stating that they had noticed a lot of change for the better in their child and 35% reporting some change. The social support measure did not reveal change in participants.

OTTAWA SKILL DEVELOPMENT PROGRAM

In Ottawa, a skill development program was offered to all children (ages 5 to 15) in a public housing complex. The skill areas were both athletic (such as swimming and hockey) and non-athletic (such as guitar and ballet). The project involved a five-year pre-intervention phase of working with parents and tenants to identify the needs and concerns of the families and to establish co-operation. The list of possible interventions included dental health, other physical health, school performance, behaviour problems and skill development. In the intervention, 42 programs involving 25 skills were offered to the children. Of the 321 children resident in the housing complex, 71% attended one or more programs.

The program was evaluated by measuring skill levels of the children, and by comparing with another housing complex according to unobtrusive measures. Preliminary results are available and indicate that fire calls and police charges against juveniles were significantly reduced in the experimental complex.

Two program implementation manuals are being written: a Handbook of Skill Levels for Sports and Recreational Activities and How to Launch a Skill Development Program in Poor Communities.

RESULTS OF EXPERIENCE — DIRECTIONS FOR THE FUTURE

In assessing the youth programs, it is necessary to consider the nature of the intervention and the rural setting of several programs as separate issues.

Program Design

A clearly structured program, rather than a very informal approach to working with youth, appears to be necessary. The advantages of structure include clarity of expectations for the whole community and lessons of consistency and focus for participants. It is more feasible to implement and to evaluate a program that has clear objectives and structure. The Caribbean Outreach Program aimed to reach a wide age-range of young people in several settings.

As with other prevention programs, an existing base in the local community facilitates program acceptance and start-up. For example, the Massey program built upon the experience of the earlier Teen Town.

Program design and start-up are particularly challenging for a remote, rural (as compared with small town) population. Among other problems is the difficulty of attracting and keeping program staff. Community and cultural values may also be a problem; entry into the community takes time. A planned approach to the entry phase is illustrated in the Ottawa project. Once the community had agreed on the intervention, it was possible to reach all the children directly with program information.

These programs, to be successful, require a critical mass of committed participants. Outreach should therefore be conducted before the program's inception, so that there is sufficient participation from the first. Schools should be approached, advertising and flyers as well as door-knocking should be used.

Delivering a Skill Development Program

As with other prevention programs, staff selected from the community and then trained may have fewer entry problems and be able to build a program more quickly.

Skill development programs may be already available, but inaccessible to poor children because of forms that must be filled out and fees that must be paid. Staff may encourage participation but not facilitate learning for disadvantaged youth. As a prevention program, the financial and psychological barriers must be removed, and real learning encouraged and supported.

Active outreach to the youth population is necessary, and will draw greater participation when the project is supported by parents and the community as a whole. Families whose children participated in the Caribbean Outreach Program continued to be difficult to reach and involve. A part of outreach should be an assessment of which activities potential participants are interested in.

The program must be flexible, to adapt to changes in group composition or changes in needs and interests of participants. The social and recreational areas should be particularly responsive to needs of participants at any one time, although the basic educational/skill development components of the program should remain relatively consistent.

The balance between the recreational and the educational components must be carefully monitored. It appears that most participants were primarily interested in the recreational component, and it may require some art to insert the educational component and still retain the interest of participants. Care should be taken, however, that the groups continue to be more than just a social club.

Evaluating a Skill Development Program

Evaluation of changes in participants' social skills and physical skills is feasible. Two of the projects discussed here devised new methods of measuring such change including skill rating scales and unobtrusive measures. It is also practical to obtain, directly or indirectly, information on the views of parents and other community members/leaders.

These programs are difficult to evaluate in part because turnover in group membership is very likely to occur in this age group. Pre- and post-tests are unlikely to prove anything significant if participation is of short duration: community impact indicators might be considered as a means of evaluating these programs.

In the Ottawa project, the collection of unobtrusive data that may be expected to change as a result of the program was a useful means of measuring program impact, including comparing two communities and deriving estimates of cost-savings related to a prevention program (e.g., reduced vandalism, fire calls).

SECTION 9: PROGRAMS FOR TEEN MOTHERS

Programs directed at teen mothers aim to improve the young woman's ability to cope with her new responsibilities by teaching her parenting skills (e.g., child care, nutrition, child development) and, by doing so, aim to improve her infant's chances of growing up in a stable, nurturing environment. Improving a teenage mother's parenting skills is expected to improve her self-concept, which is considered beneficial to both mother and child. In the first program described here, a major object was the mother's continued education. It is reasoned that a woman with at least secondary education has a better chance of being able to support herself and her baby, and of raising a healthy child. Several other programs that provide support and parenting education for teen mothers and their children are also described.

MONTROSE INFANT CARE CENTRE

Description

This program provided day care for the infants and young children of mothers attending high school. Program objectives pertained to both mothers and their infants. For the teen parents, the program aimed to facilitate completion of education, acquisition of parenting knowledge and skills, development of other life skills and a reduced pregnancy rate. It assisted the young mothers with school and work-related problems and used group meetings and informal contacts to teach parenting skills. Two parents are on the day care centre's board of directors. Through the day care component, the program intended to stimulate and nurture optimal infant development. Staff are trained day care workers.

Results

Evaluation included comparison of program mothers and infants with other groups of teens (non-mothers in same high schools) and of teen mothers (at home with their infants, using two maternity homes, and using other child care arrangements). A thorough search of other day care programs to locate a comparison group indicated that these centres do not serve teenagers.

Evaluation tools included standard measures of personality, intelligence, maturity and self-esteem. Background sociodemographic information and data on pregnancy, child care, birth control and maternal expectations were collected. Standardized tests of infant development were administered to program and comparison infants.

Analysis of evaluation data is at a preliminary stage in this project. A few results are available to report at this time.

There were relatively few differences among the groups of teenagers being studied; differences in mean age and intelligence, for example, were small. Many of the mothers (40-50%) live with their own mothers, and a sizeable minority of fathers (ranging from 26% to 45% in the various groups) provide regular financial support. A majority of fathers have contact with the child. A large majority of mothers reported engaging in beneficial health practices during pregnancy. The mothers' expectations of their own futures include finishing high school and often going on to community college.

While the differences between the groups being studied were small, initial outcome information shows that the day care program has effectively maintained mothers in school in comparison with the at-home mothers and one maternity home program. Thirteen of 14 Montrose mothers remained in school in 1982-83, in comparison with four of six "at home" mothers and five of eight mothers in one maternity home. A second maternity home had an outcome similar to Montrose with 10 of 11 mothers in school. Of the four Montrose mothers who had completed high school, three continued to community college and the fourth planned to continue the following autumn.

Data respecting the infants indicates that program infants are functioning in the normal range, as are infants in all other groups, including those at home. The initial data do not indicate declining infant functioning in any group. Demand for the day care program remains high. The Montrose program, with 16 mothers enrolled, has a waiting list of 13 and averages ten inquiries each week. A similar new day care program (Infant East) has 16 mothers enrolled and a waiting list of six. The Board of Education has started a third program.

OTHER PROGRAMS FOR TEEN MOTHERS

Several other programs providing support to teen parents are discussed briefly here although they were not evaluated.

Project Stay Healthy Early in Peterborough was intended to co-ordinate community services for pregnant, single teens and to encourage girls to take full advantage of available supports. It intended to teach the teen mothers good pre-natal health practices, parenting skills and nutrition for mother and child. The resources of community agencies with expertise in these areas (e.g., the Childbirth Association, the La Leche League, the Family Enrichment Program and the Infant Stimulation Program) were used. Referrals to the program were to be from local physicians, in the first trimester of the teenager's pregnancy.

The program was to be evaluated using an experimental/control group design, but since the program was terminated early because of lack of participants, the evaluation was not completed as planned. It was found, for example, that most teens who had babies in the local hospital were married rather than single. The program participation was widened to include married teens as well, but participation was still low. It was not possible to determine whether the requirement for referral by a local physician was an obstacle to participation or not. Other area agencies were also sought for their contact with pregnant teens.

During the time the program functioned, the co-ordinator's role and skills in working with participants were noted as being very important.

A supplemental project, jointly sponsored by the Catholic Children's Aid Society (Toronto), the Department of Public Health (North York) and York Finch Hospital, also aimed to support teen mothers. The target group was young, single mothers; the majority were in their teens although older women were not excluded. The program also served a small number of married women.

The services provided included parenting groups, pre-natal groups, a nursery for children while mothers attended parenting groups, in-home instruction and home visits to encourage attendance at groups.

Ninety-seven women, with an average grade 9 education, participated during a 13-month period. The majority had little involvement with their child's father. Most participants joined the program following the birth of their child. Most participants were working or on welfare; few returned to school.

Another supplemental award program sponsored by the Toronto Catholic Children's Aid Society was called the Early Childhood Education project. Its target group was teen parents and other parents whose young children were at risk for developmental delay. Among the services provided were discussion groups on parenting skills, child development and keeping or relinquishing the babies; training of child care volunteers; recruitment of family day care homes, and support to providers; and assistance to mothers whose children were developmentally delayed.

RESULTS OF EXPERIENCE — DIRECTIONS FOR THE FUTURE

Designing a Program for Teen Mothers

Demographics (including hospital delivery statistics) should be carefully analyzed to ensure that numbers of participants will be sufficient. The

program needs to match the actual type and scale of needs. As well, there should be an awareness of the social patterns of the area, since such factors as the likelihood of a woman choosing to give birth outside the area will affect attendance. Project Stay Healthy Early had too few participants to justify its continuation, while the Toronto programs have had difficulty in meeting the demand for service.

As shown by the program that was terminated because of lack of participants, marketing these programs is vital. In particular, referring agencies must be aware of the existence of the program and convinced of its utility. Co-operation with schools appears to be a useful way to reach teen parents.

A program such as Montrose Infant Care Centre enables parents to complete their education and thus helps ensure their future financial independence. The aspect of economic independence for young mothers is an important consideration.

Delivering a Program for Teen Mothers

Relationships with agencies serving the same target group are key to the success of a program, not only so that participants are referred to the program, but also so that participants can be referred to other needed services. For example, one program arranged for participants to attend pre-natal classes at a local maternity home.

There must be sufficient flexibility to respond to participants' needs or changing circumstances. In the Montrose Infant Care Centre, for example, participants did not wish structured discussion groups, but preferred more informal interaction with staff and with one another, so this program modification was made. In another project, group meetings were rescheduled for eight weeks to four weeks because attendance for eight weeks was often affected by premature delivery.

Use of volunteers was successful (e.g., pregnant teens from a maternity home provided child care for children of mothers attending groups, thus facilitating the mothers' attendance and learning child care skills). The only difficulty was finding sufficient staff time for training and supervision of volunteers. Training and supervision of volunteers can occur in groups, as volunteers learn effectively from modelling.

Because a common trait of teen mothers is lack of motivation, access to the program must be facilitated and constantly encouraged. Providing transportation is an important and effective way of facilitating access, and attendance can be encouraged by means of home visits.

Evaluating A Program For Teen Mothers

In areas where numbers to be served are likely to be small, a control group/experimental group evaluation may be problematic as it reduces by half the number of potential participants. A pre-test, post-test experimental design may be preferable.

Evaluation of Montrose Infant Care Centre identified questions about whether information based on studies in the United States is also accurate for Canadian populations. For example, the infants in the study are healthier than previous U.S. studies would have predicted. This raises a caution for future evaluation design based on research in other jurisdictions.

SECTION 10: COMMUNITY DEVELOPMENT AND "NETWORKING"

Community development aims to improve the quality of life in a community by helping the residents to plan and effect needed changes. It involves assisting residents to perceive their ability to influence their environment and helping them to build on their strengths. It also involves assisting residents to perceive factors that militate against needed change, and helping them to diminish or neutralize those factors. Community development is an enabling and a facilitating strategy; the worker's role is not to provide help to the target group in the traditional social work sense, but to assist the target group to help itself however it deems necessary.

"Networking" programs are a community development strategy. They attempt to identify and strengthen those natural helping relationships that exist in a community. Natural helping networks perform several functions, most importantly:

1. they provide support systems to members, including exchange of information and sharing of tangible resources (e.g., child care)

2. they enable group action to effect changes that would be more difficult for a person to achieve individually

3. by providing a forum for group action, they improve an individual's sense of competence and mastery over her or his own environment.

Community development and networking are discussed together because they are related, although not identical. Community development often results from networking, but networking aims for change at the individual as well as at the community level. Community development may well result in benefits at the individual level, but this is a less explicit goal than is the case with network-type interventions. Networking creates a foundation for community development by linking people together. The flow of information, pooling of resources and discovery of common interests provide a springboard for community development efforts.

Two prevention programs used community development/networking approaches. These were the Highland-Stirling Neighbourhood Project in Kitchener, sponsored by the Lutherwood Children's Mental Health Centre, and the Child Care Network project, sponsored by the University of Toronto.

HIGHLAND-STIRLING NEIGHBOURHOOD PROJECT

Description

The neighbourhood served by this project had a population of 3,200 in 1981; it is characterized by high density and by a high level of rental accommodation. A total of 14.8% of families are headed by single parents, compared to 10.4% in Kitchener. Families tend to have young children at home (28%). The residents have a generally lower level of education than residents of the whole city.

The project aimed to strengthen the collective capabilities of the neighbourhood in solving problems and to increase inter-personal skills and social competence in the neighbourhood youth.

Work in the Highland Stirling area actually began in 1978 when a community organizer hired by Lutherwood began to contact individuals, carried out a needs survey and helped form an organizing committee. With project funding in 1980, programs were implemented in a more systematic way. Staff were professionally trained and had community development experience.

Two main strategies were used in the program. Staff were directly involved in a series of educational programs, including parenting education, school consultation, leadership training, couple communication and support to individuals. Indirectly, staff facilitated potential leaders and volunteers to develop other programs, including adult recreational programs, children's and youth recreation and summer programs, a neighbourhood association, preschool child care, a newsletter and special events. These programs tried to encourage residents to become involved in community activities, thus strengthening supportive networks already in existence and creating new ones through a self-help approach.

Results

The focus of the evaluation was on the cumulative effects of the programs to determine whether a community development project could affect the experience of social support and psychological well-being among participants. Evaluation was by means of pre- and post-program questionnaires, which measured changes occurring in participants. Variables measured were depression, general psychological distress, social support, self-esteem and a sense of mastery. In addition, participant satisfaction was measured. A total of 183 participants completed the first questionnaire, 102 completed the second and 170 completed the third. Children were not included in the evaluation. The time elapsed was approximately 18 months.

About 60% of the program participants lived in the neighbourhood, or just on the fringe of it. Nearly 83% were women. About one quarter were employed full-time, and 20% part-time. About 30% were the primary wage earner in the family. Less than 4% were unemployed, but nearly 40% were homemakers. Over half the residents reported annual family incomes under $15,000, representing in particular the single-parent participants. Participants tended to have a higher level of education than characterized the neighbourhood.

Changes in participant well-being were measured over time.

- There was a significant increase in sense of mastery and a significant decrease in general psychological distress among participants.
- Depression tended to decrease over the time period. While the decrease fell short of statistical significance, it represented a change from 34% to 26% of the participants.
- Changes in perceived social support and self-esteem were in the predicted direction, but did not reach the level of significance.
- Results showed no difference between frequent users and less frequent users of the program, when pre-test data were controlled. It may be that any contact with the program or just knowing it is available may affect some change on dimensions measured in the study.
- Participant satisfaction was high; most participants were favourable to the program and its goals, with the majority feeling that the program made the community a better place to live and that it helped them with problems.

CHILD CARE NETWORKS (CCN)

Description

Located in the Jane-Finch area of North York, the Child Care Networks program was designed to seek out natural supportive networks and to facilitate their growth and their functioning. The emphasis was on identifying child care networks; that is, networks where the links occurred through baby-sitting arrangements. In the program's first phase, the workers assessed six neighbourhoods within Jane-Finch for numbers of working, low-wage parents with child care needs, and for low level of services for parents and children. They then undertook substantial outreach activities in each of four neighbourhoods.

Outreach took several forms: knocking on doors, being present in common areas of high-rise apartments (e.g., lobbies, laundry rooms), and visiting local groups or centres where mothers meet. In general, workers spent several months becoming a part of the community.

Staff were locally recruited paraprofessionals. The project provided training in the techniques of outreach and identifying parents' needs and strengths. Workers then aimed to establish connections between parents and to strengthen existing "networks."

Results

Workers soon realized that few natural networks existed in the target neighbourhoods, and they began building networks. This entailed further outreach with the aim of linking mothers having reciprocal child care needs. By the end of the starting phase, 74 parents had become involved in the program as the basic study sample, of whom 55 completed both pre- and post-program interview questionnaires. A comparison group of 40 people drawn from two adjacent neighbourhoods was also used in an attempt to show whether differences emerged between participants and non-participants over the evaluation period. Twenty-five of these completed both the pre- and post-tests. The program was evaluated by means of structured interviews and standardized scales administered to participants at three intervals: on first becoming involved with the project, after 6-8 months and after 10-14 months. Workers reports and neighbourhood network diagrams are part of the data base. The interviews assessed the need for child care and parent support, characteristics of parent-centred networks, and psychological well-being.

Attrition in both intervention and comparison groups reduced the numbers somewhat (16% in the program group, 38% in the comparison group). The effect of attrition, overall, was in the same direction for both groups.

Total participation in the program was about double the number in the study sample, as people continued to become involved over the entire study period.

The four target neighbourhoods were characterized by Ontario Housing (MTHC) high-rise buildings and town houses; private high-rise buildings; a high proportion of immigrants; and very few networks for child care or parent support. In three neighbourhoods, social dynamics were negative, involving racial tension and hostility, mistrust of neighbours and a history of defeat in community efforts.

The participants (73 women, 1 man) were in their late twenties and early thirties (average 29 years); 66% were two-parent families and 34% were single-parent families. The households averaged two children

including at least one child eight years or younger. Most (76%) had some high school or had completed high school. Many were immigrants (58% born outside Canada) and recent residents in their current neighbourhood (31% under one year). Sixty percent of mothers were not working. Parents were rated on 13 on-going stressor including unemployment, serious health problems, money problems, parent abuse or assault. On this scale, 33% were characterized as low stress (0-2 items), 42% as medium stress (3-5 items) and 25% as high stress (6-10 items). Social isolation was a factor with over half the families.

Comparison group members differed from the program group in that they were younger and had fewer children, and that fewer lived in MTHC buildings. This suggests that the comparison group were relatively less disadvantaged and that improvements in the program group may be conservatively estimated.

Analysis of data concentrated primarily on two of the four experimental neighbourhoods and the comparison group. In the other two neighbourhoods, workers spent more time with participants who were not part of the study sample, people moved because of rent increases, and one worker went on maternity leave about halfway through the program. For these reasons, data for these two neighbourhoods were assessed as part of the process evaluation, but were not compared with other neighbourhoods.

Results included:

- In the two neighbourhoods analysed, there was a significant improvement in parental support needs met in contrast with the comparison group.

- The need for child care support was reduced for the program group in contrast with the comparison group; the difference approached significance.

- While depression and loss of control decreased for both groups, there was no significant improvement in the program group over the comparison group. There was no effect on either group in self-esteem.

- In the four neighbourhoods, between 27% and 56% of parents reported new network members.

In each neighbourhood, one or more community groups was organized to address immediate neighbourhood needs (e.g., false fire alarms) or on-going needs (e.g., parent-child drop-in groups, women's groups and recreational programs).

RESULTS OF EXPERIENCE -- DIRECTIONS FOR THE FUTURE

Designing Community Development/Networking Program

Clear goals and strategies are vital. Because these programs, by their nature, respond to community needs, there is a tendency for workers to act reactively rather than to carry out a planned intervention. Clearly expressed program goals and strategies against which workers can compare their use of time should help retain the program's focus.

The planning stage should include some outreach and involvement of community residents so that community members are consulted about which interventions would best meet their needs. This is a time-consuming process, but appears to result in higher eventual participation.

Community development/networking programs are extremely slow to start up. They require a substantial planning period, to ensure that activities, once commenced, are focussed. They also require substantial outreach, as the target population is isolated and suspicious of government-funded programs. This type of intervention must be planned with the expectation that the first several months to a year of the operation will show few results or even concrete activities.

Delivering A Community Development/Networking Program

Staff need to know and understand the target community and population. Staff recruited from the program area will find it easier to make and retain contact with other residents. Formal qualifications (e.g., education) are less important; however, staff training may be necessary to develop administrative and planning skills.

Staff without formal qualifications will also need social work supervision. When they encounter community residents who are experiencing serious problems, for example, they will need the guidance of someone with formal social work qualifications to assist them in determining an appropriate response (e.g., referral to another agency). Workers should be trained to recognize situations calling for interventions beyond their capabilities, and outside the program's mandate.

In operating these programs, the process of getting people together is important in itself; actual activities engaged in are less important, and direction for this should come from participants.

The experience of the Child Care Network program shows two important things about linking people for purposes of exchanging child-care assistance. First, linking up two people does not always work; the

match may simply not take. It proved more effective to get people together in groups, and to allow them to begin to establish connections. Second, preliminary evidence suggests that it is difficult to start networks focussed on sharing child care responsibilities; it proved easier to mobilize people around involvement in neighbourhood issues. It may be that the level of trust required to exchange child care services is extremely high and takes longer to develop.

Community development/networking programs often receive referrals from treatment services (e.g., children's aid societies). This can present problems for several reasons. It may affect (or may appear to affect) the voluntary nature of participation in prevention programs. Program workers may spend a great deal of time with a few very needy individuals, thus altering the community focus of a program to a more traditional casework focus. It may confuse the issue of who has legal responsibility for supervising a family. These problems need to be confronted in program planning. While workers may wish to meet every demand encountered, clearly stated goals and objectives, and ongoing documentation of activities should assist in retaining the program's community focus and prevent a transition to a casework focus.

The preceding does not negate the importance of working with individuals on a one-to-one basis. A number of individual contacts with a particular resident may be necessary before that person is prepared to become involved in community activities, and clearly this is time well spent. It is a question of maintaining a balance in the program.

Evaluating Community Development/Networking Programs

Evaluation of these interventions needs to recognize slow program starts and the fact that changes in individuals may not be dramatic. Locating and engaging a valid comparison group is time consuming and difficult. Measuring the effectiveness of individual program components is even more difficult than measuring total program effectiveness, because the number of participants is smaller. The same problem applies to attempts to measure effectiveness by neighbourhood.

Spin-offs of the programs (e.g., neighbourhood improvements that occur as a result of actions by participants after their involvement in the program) are an important aspect of evaluation. They are sometimes difficult to recognize or measure; this needs to be considered in evaluation design.

As in prevention programs discussed earlier, it may be possible to make greater use of unobtrusive data (social indicators, such as vandalism rates or police calls, that do not require approaching individuals for information but use readily available community data) to check on total community effects. One advantage of using unobtrusive data is avoiding the intervention effect of data collection.

It is important to track worker activity relative to program goals, since these programs, being reactive in nature, tend on occasion to diverge from their original intent.

A number of interesting questions remain unanswered, including:

- Are networks or social support that are artificially created by program interventions as effective in buffering people against stress as naturally occurring supports?
- To what extent can individual and community change be attributed to the program, as opposed to extraneous variables unrelated to the program?
- Will created networks and community groups continue once worker support is withdrawn?
- What proportion of target population is reached by community interventions, and at what unit cost?

In sum, our knowledge about community development/networking as a preventive intervention is in its infancy; potentially the pay-off from these programs is high, particularly in terms of spin-offs that may occur. It is an area that particularly needs further study in order to increase our knowledge base.

SECTION 11: SCHOOL-BASED PROGRAMS

Three program assessment awards ran school-based programs. These were the Caribbean Outreach Program, the Northeast Neighbourhood Centre and the Highland-Stirling Neighbourhood Project. In general, these programs were intended to improve a child's functioning in the school system by increasing his or her competencies and by increasing the ability of teachers to deal with children having special needs or at risk of developing special needs.

CARIBBEAN OUTREACH PROGRAM (COP)

Description

A supplementary education program operated by the COP consisted of regularly scheduled sessions of remedial upgrading in academic skills. It also aimed to facilitate positive role identification and good school attitudes in students. During 1981-82 the program was provided to fifth and sixth graders in three schools in North York; in 1982-83 it was provided to the same grade levels in four schools. Students left their classrooms for a period of special assistance with a certified teacher of West Indian background. Approximately 15 children per school per year participated, for a total of 105. Data for the first year indicated that 85% of the children were born in the Caribbean or West Indies; about 71% of children in this program had lived in Canada for five years or longer.

Results

The program was evaluated using a pre-program test and a post-program test. Academic areas tested were speed reading, arithmetic and spelling. In addition, a grammar test was developed that tested the child's command of English as spoken in Canada as opposed to English as spoken in the Caribbean. Other instruments measured self-esteem and school attitudes. Finally, regular classroom teachers' opinions were gathered through a Behaviour Rating Checklist (North York Board of Education).

Data were collected on 45 students attending grades 5 and 6. On three of the four academic tests (reading, arithmetic, spelling and grammar) improvements reached statistical significance. These scores are difficult to interpret, however, because there was no control group. In arithmetic and spelling the scores represent about a grade equivalent gain. The speed reading test could not be scored in this way because children were given more than the standard time to complete the test.

There was a small but statistically significant improvement in self-concept of children over the school year, and a small but non-significant improvement in well-being. In terms of the quality of school life scale (child and teacher ratings), and teachers' ratings of the child's academic potential, none showed statistically significant differences between spring and fall, although some positive movement can be observed.

The response of classroom teachers to the value of the program for each student was mixed. Forty-three percent were unable to rate the program's value for their students, 35% felt the program had been of value and 22% felt it had not been valuable for their students.

NORTHEAST NEIGHBOURHOOD CENTRE (NNC)

Description

Northeast Neighbourhood Centre's school program employed school consultants to work with teachers, principals and day care supervisors in schools and day care centres in the community served by the project. Two classroom consultants were contributed by the North York Board of Education and the Metro Toronto Separate School Board. The object was to enhance the quality of learning opportunities for children, and to increase competencies among teachers and children. The consultants assisted teachers to provide individual and group programming for children identified as high risk. Consultants also acted as a liaison between parents and teachers when necessary. The initial contact between consultant and teacher often concerned a child identified as a problem, but the consultant's role then broadened into more general assistance to the teacher, focussed on ways of dealing effectively with the class.

It appears that a shift in emphasis naturally occurred at some point in the consultation. Initially a consultant was asked to intervene in the cases of specific children. Later, after this difficulty was resolved and rapport was established between consultant and teacher, the consultation shifted to producing a stimulating learning environment for the whole class.

Consultation was available in seven primary schools and three day care/nursery programs. A total of 34 staff and 620 students were involved during the evaluation period.

Results

All the teachers (N=28) in the school consultation program were interviewed. A sub-sample of 10 elementary teachers was compared with a control group of 14 primary teachers selected from six area schools not involved with NNC.

To evaluate the program, four instruments were used. A teachers' questionnaire, developed from several instruments previously used for evaluation of similar programs, required teachers to state the extent to which various aspects of the consultation had been useful to them. The teachers' impressions questionnaire elicited general impressions from teachers and compared these with impressions of control teachers using other available school consultation. Another questionnaire required consultants to state the extent to which the consultation had been useful to teachers, and to assess where they felt teachers could benefit from assistance. Another questionnaire elicited impressions of consultants about the usefulness of the service they provided.

Responses of the 10 participating teachers indicated an increase in the perceived usefulness of consultants and a reduced need for assistance and amount of job difficulty. The teachers who had used the consultation program perceived significantly less need for assistance and a significantly greater improvement in organizational climate during the course of the program than did the comparison group. In addition, the former group reported a decrease in school-related difficulties to a significantly larger extent than was reported by the comparison group. The teachers receiving consultation reported being unclear about the goals of the consultation. However, on a five-point scale, they rated the program as either very valuable (15%) or extremely valuable (85%), whereas comparison group teachers (n=14) rated existing school consultation as moderately (80%) or very valuable (20%).

The school consultants' perceptions of the usefulness of the program indicates that certain aspects of the program were seen as more useful and more needed than others. Those seen as most useful and needed were providing information, helping teachers identify children with special needs and helping teachers communicate more effectively with parents. It appeared that teachers required less assistance in areas such as maintaining classroom discipline, helping children work and play together, and collaborating more productively with other staff and school administration. Accordingly, the consultants rated these elements of the program as less useful.

HIGHLAND-STIRLING SCHOOL CONSULTATION PROGRAM

Description

The school consultation component of the Highland-Stirling Neighbourhood project aimed at improving teacher skills, student competencies and liaison between school, child, family and community. The school was selected in the project neighbourhood on the basis of perceived need and school staff interest. Four classes of grade 7 students were involved (n=60).

Variations on the approach to consultation included:

- o consultation with teachers and students
- o consultations with teachers and students and efforts to involve parents
- o consultations and parent involvement, as above, plus more intense interactions with students.

A fourth class comprised the control group. Staffing for the consultation was provided by a community worker on the project.

Results

Evaluation comprised pre-post measures of teacher perceptions of student behaviour, the Devereux Elementary School Behaviour Scale, school grades, and parent and student satisfaction scales, as well as demographic data. The interval was three school terms.

In general, there were no discernable treatment effects. Group changes were random and inconsistent. In some instances, post-test scores were significantly worse than pre-test scores. Nonetheless, parent and student ratings of the program ranged from positive to very positive, with few low ratings. Interviews and observations indicate that teachers did become increasingly skilled in handling classroom situations. It is suggested that the short interval of the consultation did not permit changes in the desired direction.

RESULTS OF EXPERIENCE — DIRECTIONS FOR THE FUTURE

Planning a School-Based Program

An excellent reason for developing school-based programs as a prevention strategy is that the setting is non-stigmatizing. In the course of the NNC evaluation, parents were asked to select preferred locations for prevention programming. They chose as desirable sponsors

for prevention programs those agencies that deal with average children (e.g., Board of Education, YMCA's, Recreation Department) rather than those agencies dealing with children identified as having problems (e.g., children's aid societies or children's mental health centres). This finding is confirmed by Shoom-Kirsh, et al. (1981). Because the school system provides a universal service, it presents an ideal opportunity for early identification of children likely to develop problems later on, and therefore an opportunity to intervene early in the formation of those problems.

Teachers who will be participating in a school consultation program should be involved in the planning stage. This would ensure that they understand the objectives of the program, and would make their commitment to it more likely. It would allow them to express their needs for various forms of assistance in order of priority. A program is, almost by definition, likely to be more effective when all parties understand and agree to its objectives. A clear demonstration of such a commitment occurs when the Board of Education assumes partial financial and operating responsibility for the program.

When choosing a target population for a school-based program, the two main criteria should be (a) likelihood of a high-risk population being reached (this can be determined through demographic analysis) and (b) expressed interest of school administrators and teachers in participating in such a program. A school-based program may be particularly suitable for teaching and enhancing children of visible immigrant and minority groups, for example.

Providing a School-Based Program

Because the consultant's role is multi-faceted, she should constantly refer back to the objectives of the program to ensure that the majority of her energies are expended on activities that directly relate to these objectives. This prevents the consultant from being totally reactive to daily demands of teachers and spreading resources too thinly.

The consultant's major efforts should go towards building the confidence and competence of teachers, and assisting teachers to do the same for students. Too much time spent by a consultant working one-to-one with a student perceived as having problems may not assist the teacher, unless the teacher is learning how to continue the approach initiated by the consultant. Often the initial contact between teacher and consultant concerns a child with particular problems, but if the consultant's role stops at this point or continues with the individual child, a treatment rather than a preventive program is being provided.

Evaluating School-Based Programs

The evaluation of NNC reported on a review of 71 evaluations of school consultation published between 1979 and 1982. High success rates were often reported despite methodological flaws. Most are reported to have lacked adequate sample size, appropriate controls and statistical analysis. It is extremely difficult to design means of measuring the effect of school consultation on teachers and students.

The Northeast Neighbourhood Centre evaluated the program according to the response and impressions of both teachers and consultants. This is essentially a provider and user satisfaction survey, and thus leaves unanswered questions about the effectiveness in altering classroom method or pupil outcomes.

The Caribbean Outreach Program tested the academic and attitudinal changes of participants over time, and showed some statistically significant results; these results, however, would have been considerably more compelling had a control or comparison group been used. As it stands, it is difficult to attribute change to prevention intervention or regular classroom instruction. Carefully controlled studies of school-based interventions are necessary to draw conclusions about approaches that appear to have promise.

There is scope to estimate the outcome of these programs, particularly where specific improvements in various aspects of school performance are being sought. This requires a comparison group, and a clear description of program goals.

SECTION 12: HOME VISITING PROGRAM

A home visiting program provides support to individual families because of needs or risks identified for that family. Home visiting refers to in-home efforts to teach parenting education, child development, home management skills and other skills and information pertinent to the particular family's needs.

The home visiting program discussed below is the only example among the prevention projects of a program that focussed on individual families rather than on groups or communities. It illustrates the close relationship between prevention and family support concepts. For program providers, it illustrates the challenge of maintaining a preventive approach as distinct from treatment. In selecting the prevention projects, it was decided to include one home visiting program that was part of a comprehensive community program that included drop-ins and school and day nursery consultation. As part of its prevention program, the Northeast Neighbourhood Centre operated a home visiting service for North York families.

NORTHEAST NEIGHBOURHOOD CENTRE

Description

The community served by the Northeast Neighbourhood Centre (NNC) is described in Section 7. Participants in the NNC home visiting program were referred by the local public health team and other agencies, or were self-referred. Initially, the criteria for inclusion in the home program were developed for use by local public health nurses during their regular post-natal family visits. The criteria included physical health (neonatal or postnatal problems, illness, developmental problems), interpersonal situations (family well-being, availability of support), physical environment (shelter, food) and socio-cultural factors (languages, expectations of child).

The skilled home program worker visited about thirty families each week. In the home she discussed specific problems with the parents or children, and often worked beside the mother to observe problems and/or model and teach different skills.

Results

The program was evaluated by a pre-test, post-test design. Data collection included information about the background and well-being of participating families, information about their children and parenting,

client satisfaction measures and assessments by the home program worker. A number of standardized scales were used, as well as interviews and questionnaires designed for this program.

In total, about 35 families were involved each year. The study sample of 20 mothers included all those entering the home visiting program during 1981-82 who were likely to be involved over at least six months. The evaluation did not document how the criteria were used in practise to refer families to the program.

The parents were predominately married (98%), between ages 25 and 35 (95%), and middle class (90% of spouses in professions, business or services).

In general, very few scores on the standardized tests showed any significant changes over time. In some instances this may be attributed to the fact that high initial scores left little room for improvement on the post-test.

There was a significant decrease in the amount of problematic child behaviour observed by mothers, and a significant increase in the extent to which parents reported trusting their children. Mothers' confidence that they could deal successfully with their children also increased significantly. Numerous other scales assessing possible changes in attitudes or behaviour were administered, but no significant findings emerged. These results are limited and do not support any definite conclusions about program effectiveness.

On consumer satisfaction measures, ratings were initially positive and remained so in the post-test. There was a significant increase in the sources of social support for the mother, which may indicate the presence of the home worker. Mothers respected the experience and knowledge of the home worker and saw her as a friend.

RESULTS OF EXPERIENCE — DIRECTIONS FOR THE FUTURE

Designing and Delivering a Home Visiting Program

Home visiting has been tested as part of a project that links participants with other services. Parents may also use the drop-in, and school consultants visit the child's classroom. This aspect of integration with other services may be an important design consideration.

This type of intervention illustrates the fine balance between prevention programs and treatment. Can the possibility of incipient, serious problems be identified early on, and can a home visiting

program teach the knowledge and skills necessary to reduce the likelihood of such a result? Further, can the preventive aspect of a home visiting program justify the unit costs involved?

Close co-operation with the referral sources is necessary to define eligible program participants, to screen out referrals for treatment, and to maintain program integrity. Although a battery of measures was used on the NNC test sample, few scores showed substantial change. It is necessary to define the target population for a home visiting program very carefully.

Evaluating a Home Visiting Program

An evaluation design involving a no-treatment control group is necessary before conclusions can be reached about a home visiting program. Several questions remain unanswered, including: Do problems solve themselves over time? Is a professional staff person most suitable? What happens when the home visitor leaves? Can these needs be met by other less intrusive and perhaps less costly means?

SECTION 13: SUPPORT FOR PRIMARY PREVENTION: RESEARCH, TRAINING AND PUBLIC EDUCATION

Support for primary prevention entails more than funding specific program interventions. As discussed in Section 3, the strategies employed in prevention have also included basic research through an epidemiology unit established at McMaster University; prevention training for agency staff and community volunteers; and public education and promotion of prevention. These are all ways of enhancing knowledge and skills in prevention and of changing attitudes toward an awareness of primary prevention. Each strategy is discussed below.

PREVENTION RESEARCH

Basic research in primary prevention has been undertaken through an Epidemiology Unit, directed by Dr. D. Offord, McMaster University. Prevention research has also been supported by provincial lottery funds administered by MCSS. The results of research are published in various journals, as studies are completed.

The Epidemiology Unit has worked on three tasks pertinent to prevention. First, information systems in MCSS and other ministries dealing with children were searched for information relevant to planning prevention. Recommendations were presented for future design of information systems. In the second task a number of childhood emotional problems (such as anorexia nervosa and speech disorders) were identified as being especially damaging to children. The literature is being reviewed for ways to prevent such conditions and the strength of such evidence. When complete, these reviews will appear in The Journal of Preventive Psychiatry. One review, on the prevention of child abuse, is discussed in Section 2 of this report.

The Epidemiology Unit's third and largest task has been to design, conduct and analyse a province-wide survey of the prevalence of children's emotional and behavioural problems. Known as the Ontario Child Health Survey, it has gathered data on a representative sample of Ontario households including children aged four to sixteen. The survey is unique in several respects, including the use of a household as the sampling unit and the inclusion of children of such wide age-ranges. Data have also been collected from the mother, from children over age eleven, and from each child's teacher.

Three main categories of data were collected:

- o risk factors, including demographic information, family history
- o health status, including levels of well-being and symptoms designating conditions, such as hyperactivity or anti-social behaviour
- o consequences, including impairments and service utilization.

The data resulting from the survey are expected to be useful in several ways.

- o accurate estimates of prevalence of conditions or clusters of symptoms, for different regions of the province, and relationship with risk factors
- o relationship between prevalence of conditions and service utilization
- o utility in service planning
- o development of hypotheses about etiology, natural history or treatment outcomes for future studies
- o baseline data for future studies
- o development of design and instruments for further use.

The Epidemiology Unit has also developed a core of research expertise in the area of prevention and children's services. The Unit has a student training function as well. It is available to provide on-going research support to the Ministry in prevention and related service areas. Currently, it is conducting a clinical validation study of childhood emotional and behaviour problems as identified in the survey. Future work may include the problems of native children (omitted from the first survey due to costs and methodological constraints), and further studies of the efficacy of primary prevention.

TRAINING IN PREVENTION

Training in primary prevention has been addressed through delivery of training workshops in locations throughout the province for agency staff and volunteers, and development of training materials in the form of manuals as a resource for continued prevention training. The two agencies that have been working on training activities in prevention are Dellcrest in North York and the Human Services Community in Guelph.

The approaches to prevention training has included workshops both on developing prevention programs and on teaching interpersonal skills for coping with life problems. A total of 42 workshops were held in 18 different locations. Participation totalled 881 people.

Training in Prevention Program Development

Manuals on prevention program development (available from Dellcrest) include:

1. Enjoying Your Infant — A Program Manual.
2. The Parent-Child Resource Drop-In Centre.
3. Problem-Solving Training as a Prevention Strategy.
4. Volunteer Program Development.
5. Mental Health Consultation as a Prevention Strategy.
6. Prevention Program Development in Times of Constraint.

Workshops were held on these topics and, following the workshops, consultation about prevention was provided to interested agencies. In the first phase, to May 1982, consultation meetings were held with 116 individuals; three organizations received substantial consultation services.

Several months after the workshop series had concluded, a telephone survey was conducted with a random sample of participants. Fifty-three people were interviewed, and asked a series of questions about the utility of the workshops.)

Table 13.1 shows the number of respondents from each workshop. Approximately two-thirds of survey respondents indicated that they had both gained knowledge/skills from workshops, and had incorporated ideas in their own agency. The types of agency program change included: changes in case planning or program planning, increased staff discussion of prevention, and increased interagency collaboration. Most notable were six responses of changes in budget to increase the emphasis on prevention.

TABLE 13.1: UTILITY OF PREVENTION TRAINING WORKSHOPS

Workshops	Number of Respondents	Gained Knowledge & Skills		Incorporated Ideas in Own Agency	
	Total N	N	%	N	%
Prevention Program Development in Times of Constraint	5	4	80	2	40
Prevention Services for Preschoolers	16	11	69	7	44
Problem Solving as a Prevention Strategy	25	13	52	16	64
Developing a Volunteer Program for Prevention	16	13	81	12	75
Mental Health Consultation	1	1	100	1	100
	63*	42	66	38	60

* Some respondents attended more than one workshop.

Subsequent consultation in 16 locations has identified the types of concerns agencies and community organizations experience in planning prevention. These concerns are summarized briefly here:

- o teenagers as parents
- o programs for preschool children
- o individual programming for children with special needs
- o community base versus agency base
- o community support and collaboration
- o reaching high-risk parents
- o funding strategies
- o evaluation.

Training in Development of Coping Skills

Manuals in interpersonal skills for coping with problems (available from the Human Services Community) include:

1. Basic Communications
2. Patterns in Relationships
3. Conflict Resolution
4. Adult-Child Relationships
5. Leadership Training

Intensive work with a core group of 20 participants has prepared them as leaders to provide further training and implement coping-skills methods in a variety of settings. Examples of the application of this approach include use with foster parents, "alternative-to-care" programs, volunteer crisis counselling, programs for elementary and high school students and volunteer family support workers.

PUBLIC EDUCATION IN PREVENTION

In Section 2 of this report, there is a brief discussion of the types of primary prevention programs, including community-wide programs. These tend to be educational in nature and to use various media to reach a wide public. Ministry public education activities in prevention have consisted mainly of the Positive Parenting series of pamphlets and TV commercials. Started as part of child abuse prevention, the Positive Parenting series is targeted on the parents of young children and aims to reinforce good parenting practice and to give useful advice to parents.

In French and English, the pamphlets provide information on child development and suggest methods of dealing with common and frustrating problems of parents, such as discipline, sibling rivalry and night waking. Complementary TV ads have been designed on toilet training, sibling rivalry, night waking, nurturing and discipline. The

Positive Parenting pamphlets have had the widest distribution of any Ministry publication available through Ministry offices and social service agencies. At one time the pamphlets were distributed through in-store displays by Procter and Gamble. How to distribute material efficiently to the parents of young children remains a challenge for the Ministry.

The TV messages deal directly with parental frustration using a copy line "You're not alone," which conveys the idea that other parents experience similar frustration in raising young children, and that helpful information is available.

A test was conducted of the commercials on prime-time TV, rather than in public service announcement spots, in order to measure the impact of the series (Ratcliffe and Wittman, 1983). A benchmark survey and two follow-up surveys were conducted. Each wave comprised a separate sample of 300 mothers of young children, interviewed by telephone for approximately 20 to 30 minutes with a co-operation rate of 97% of qualifying respondents. Over the test period, the study showed significant positive shifts in opinions about child-rearing, and positive reactions to the messages. In the two post-campaign surveys, mothers consistently reported behaviour change as a result of seeing the commercials (22% in Survey 2 and 21% in Survey 3). Similarly mothers aware of the pamphlets reported being influenced by them (26% in Survey 2 and 30% in Survey 3). In contrast with respondents who were unaware of the campaign or unchanged by it, "significantly more mothers, who were aware of the campaign and felt changed by it, reported that their recent experiences with and behaviour toward their young child changed quite a bit in line with campaign objectives" (Ratcliffe and Wittman, 1983: 104).

Subsequently, a province-wide campaign was run, and evaluated immediately following the campaign by a survey of 306 mothers in seven urban centres. The results indicated similar positive changes in behaviour and feelings toward their young children.

While this research is not conclusive, it does suggest that media intervention is one means of fostering more positive family environments for young children. Other questions remain to be researched, including, for example, any actual reduction in the incidence of child abuse, and the durability of the message's impact. (For further discussion, see Ratcliffe and Wittman, 1983).

SUMMARY

Efforts to enhance prevention require more than program funding. It is necessary to continue to increase our knowledge base relevant to prevention, and to transmit this knowledge and skills as widely as possible. Increasing awareness of prevention and skills in program development among staff in agencies and community organizations and many volunteers requires continued efforts in prevention training. The social services field in Ontario and elsewhere will benefit from continued research of topics basic to prevention and pertinent to improving our knowledge of where and how to intervene. Widespread public education methods appear to be a promising approach to reaching a large number of people with messages that enhance their ability to cope.

In each of these areas, potential areas for future work have been identified.

For example, training needs have been identified

- for Ministry staff in prevention implementation
- for staff of service agencies or organizations in development of prevention programs and skills, and in collaboration among groups
- for staff of prevention projects in administration, planning and supervision skills.

In basic research, there are many unanswered questions about the nature of childhood problems, and possible methods of protection or prevention. These include, for example, a more culturally unbiased examination of problems experienced by native and immigrant children.

The use of public education and promotional efforts to enhance family environments and to help change attitudes toward a more supportive society for children and families is a promising area for further development and study.

APPENDIX 1: PRIMARY PREVENTION PROJECTS BY REGION

The following table gives a partial overview of the types of prevention projects being operated in different parts of the province. It was compiled by requesting that Area offices identify local prevention programs, and then by selecting those programs which appear to meet the definition of prevention. It is not a complete or consistent inventory. It illustrates the range of prevention programs and the overlaps with family support and informal day care projects.

APPENDIX 1: PRIMARY PREVENTION PROJECTS, BY REGION

Region	Project Title	Type of Sponsor	Type of Intervention
Southeast Region			
Prescott-Russell	Parenting	CAS	Parent training courses; transportation and babysitting available
Vanier	Service Integre Familial	CAS and Youth Services Bureau	Family support
Ottawa-Carlton & Prescott-Russell	Catholic Family Service	Family service agency	Parent effectiveness in francophone community
Napanee	Family Resource	CAS	Parent-child drop-in programs; volunteers
Lanark	Parent Resource Program	CAS	Parent-child drop-in; home visiting
Kingston	Nor'h Kingston Community Development Program	Local board of directors	Community development program; store-front centre; parent-child groups single-parent group, home skills, parenting program for fathers

Region	Project Title	Type of Sponsor	Type of Intervention
Southeast Region			
Kingston	Helen Tuffs Day Nursery Program	Day care centre	Consultation with nursery schools; parent groups; home visits
Peterborough	Family Resource Centre	Peterborough Parenting Program	Parenting support, counselling, self-help groups, toy lending
Haliburton	C.H.A.C.E. - Resource Centre	County Agency for Child Enrichment	Parenting support, counselling, self-help groups, toy lending
Lindsay	Victoria County Mobile Resource	Children's Services Advisory Group	Travelling van, family support, 15 rural communities
Oshawa	Preschool Case Co-ordination Program	Regional Health Unit	Co-ordination and management of services to prevent conditions leading to physical, emotional or developmental problems in preschool children
Southwest Region			
Hamilton/Brant	Caring Adults, Loving Mothers	CAS	
Waterloo	Home Care Program	CAS	Life skills training; support groups

Region	Project Title	Type of Sponsor	Type of Intervention
Southeast Region			
Milton	Milton Centre	CAS/local board	Community centre; mothers groups; teen drop-in groups; pre-school program
London	Family Life Education	CAS	Parenting education, teens group; toy library; marriage preparation and enrichment
Sarnia	Parent Education Prevention Outreach Program	CMHC	Outreach and parent group; preschool nursery
North Region			
Larder Lake	Drop-in Centre	Diocese	Leadership training for teens
Hearst/Kapuskasing	La Source	Local board of directors	Drop-in; leadership training; adolescent programs
Sudbury	Birkdale Village	John Howard Society	Community resource centre; drop-in; self-help groups
Thunder Bay	Parent Link Programs	Confederation College and CAS	Leadership training for volunteers in isolated communities; volunteers provide workshops discussion groups

Region	Project Title	Type of Sponsor	Type of Intervention
Central Region			
North York	Jane Finch Parent-Child Centre	Local board of directors	Parent-child drop-in, associated parenting and group activities; community resource centre; home visits; mental health drop-in; women's groups; co-op nursery school
North York	Young Mothers Support Project	CAS and Department of Health	Prenatal and postnatal support and service co-ordination for teen mothers
	North York Interagency Council	Municipality	Community development and service co-ordination
	North York Prevention Project	Day care centre	Education and development of support system for family day care providers
Scarborough	Early Childhood Education-parent child centre	CAS	Child care training for parents, volunteers, and foster day care parents
Metro Toronto	Teen Mothers	YWCA	Outreach service
	Jessie's Centre for Teenagers	Local board of directors	Resource centre; respite care; crisis intervention
	Portuguese Outreach Project	COSTI-IIAS Immigrant Services	Family support for immigrants

Region	Project Title	Type of Sponsor	Type of Intervention
Central Region			
	Children's Storefront	Local board of directors	Drop-in; parent education; relief and support services; home visits
	Creating Together - Parkdale	Local board of directors	Community resource centre; toy library; baby-sitting co-op
	South Riverdale Child Parent Centre	Local board of directors	Drop-in; community resources; outreach; home visits; support services
	Day Time	Local board of directors	Drop-in; community resource; self-help groups
	Family Life Connection	Day care centre	Drop-in; community resources; baby-sitting co-op; home visiting
	River Oak Parent-Child Centre	Parent Resources board/CAS	Drop-in; community resources; home visits; support services
	Together Parent-Child Centre	Advisory Committee	Drop-in; community resources; parent relief; home visits.
Richmond Hill	Thornhill Family Services	Family services association	Educational and support services for teens; parent self-help groups
Aurora/Newmarket	Family Life Centre	Local board of directors	Parenting education

APPENDIX 2: SYNOPSIS OF PREVENTION PROGRAM ASSESSMENT PROJECTS

TABLE 1. CARIBBEAN OUTREACH PROGRAM

Sponsor

Jamaican Canadian Association
Co-ordinator, Bev Folkes
Evaluator, Dr. Michael Efran

Objectives

1. To provide parenting support, reduce isolation of immigrant parents and develop self-help groups.
2. To develop links between family and school, and provide education about the Canadian school system and parent/child relationships in the new society.
3. To provide upgrading classes for immigrant children.
4. To establish links between the West Indian community and other ethnic groups for mutual understanding and sense of community.

Target

West Indian immigrant families.

Program components

1. Direct services including crisis intervention, counselling and job search assistance.
2. Parenting program.
3. Youth groups.
4. In-school up-grading course for grade 5 and 6 students.

Staffing

Paraprofessionals selected from target communities. Professional teacher.

Evaluation design

Pre-test, post-test, no control group.

Measures

1. Structured interviews.
2. Assessment of parenting knowledge and child behaviour change.
3. Achievement test; self-concept scale.
4. School attitudes questionnaire.
5. Teacher ratings.
6. Scales of social support and affect balance.

TABLE 2. CHILD CARE NETWORKS

Sponsor

University of Toronto, Faculty of Social Work
Co-ordinator, Dr. Eilene McIntyre
Evaluator, Penny Lawler, the Lawler/Dean Partnership

Objectives

To increase the level of child-care support for parents by creating and/or strengthening ties between parents in neighbourhoods.

Target

Parents with preschool children in low-income, high-density suburban neighbourhoods.

Program components

1. Outreach to parents in four neighbourhoods.
2. Identification of existing child-care networks.
3. Support to isolated parents and activities to link parents around child care and other needs.
4. Support to new self-help groups of parents.

Staffing

Paraprofessional workers selected from target neighbourhoods.

Evaluation Design

Pre-test, post-test of four experimental groups and two control groups.

Measures

1. Diagrams of parent-centred child-care networks showing, for example, membership and relationship.

2. Diagrams of neighbourhood networks.

3. Indices of child-care needs.

4. Measures of participant well-being, depression.

TABLE 3. HIGHLAND-STIRLING NEIGHBOURHOOD PROJECT

Sponsor

Lutherwood Children's Mental Health Centre
Co-ordinator, Doris M'Timkulu
Evaluator, Dr. Alan Cohen in conjunction with
F.J. Turner & Associates, University of Western Ontario

Objectives

1. To increase interpersonal skills and social competence in pre-adolescents and adolescents.

2. To strengthen the collective capabilities of the neighbourhood in problem-solving and decision-making and to increase health-promoting forces in the neighbourhood.

3. To determine the extent to which a community development project is able to affect the experience of social support and/or psychological well-being of participants.

Target

Families in a neighbourhood characterized by low income, high transiency, social isolation, and lack of recreation and social services.

Program components

1. Groups for children and youth.

2. Social support groups for adults.

3. Parenting education.

4. School consultation.

5. Volunteer and leadership development.

Staffing

Professional staff and volunteers.

Evaluation design

Focussed on measuring changes in social support and psychological well-being, using time-series measures of participants to compare "high" and "low" users of program.

Measures

Previously validated measures of social support, psychological distress, life stress, self-esteem and mastery. Established measures of demographics and attitudes toward programs.

TABLE 4. MONTROSE INFANT CARE CENTRE

Sponsor

Board of Education of Toronto
Co-ordinators, Julia Mathien and Asali Quamina
Evaluators, Martha Friendly and Gail Gondo, Child in the City
Dr. Fred Weizmann, York University

Objectives

1. To provide infants of adolescent mothers with a stable environment while their mothers attend school and to encourage optimal infant development.

2. For mothers, to complete their education to the same level as could be expected without motherhood.

3. To acquire parenting knowledge and skills, and skills central to being provider for a child.

4. To reduce the rate of additional pregnancies during participation in the project.

5. To enhance self-confidence and self-esteem, and develop necessary support including appropriate social services and informal personal support.

Target

Teen mothers enrolled in several urban secondary schools.

Program components

1. Infant day-care program.

2. Support to mothers to continue their education; guidance about child development and child care, future pregnancies, parenting.

Staffing

Professional day care staff.

Evaluation design

Pre-test, post-test, measures of program mothers and infants; comparison groups of non-mothers, at-home mothers and teen mothers using other support programs.

Measures

1. Structured interviews/questionnaires for mothers.

2. Developmental tests for infants.

3. Measures of mother-infant interaction.

4. Parent background, demography.

TABLE 5. NORTHEAST NEIGHBOURHOODS CENTRE

Sponsor

Adventure Place
Co-ordinator, Don Wale
Evaluator, Dr. Richard Volpe, Institute of Child Studies

Objectives

1. To enhance quality of parent-child interaction and sense of agency and competency.

2. To enhance quality of learning opportunities for children and professional competencies.

3. To facilitate development of support networks among community residents.

4. To enhance the community's ability to serve itself.

Target

Parents, children, teachers and day care staff in suburban community including subsidized housing developments.

Program components

1. Home visiting program for parents referred by public health unit.

2. Drop-in centre.

3. Consultation to teachers and day-care staff.

4. Education/professional development activities with local agency staff and parents.

Staffing

Professional staff seconded from a children's mental health centre; two teachers sponsored by local boards of education.

Evaluation design

Pre-test, post-test of each component.

Measures

Home Program

1. Parent background information.
2. Assessments of parental attitudes, well-being, communications with child.
3. Self-confidence.
4. Staff assessment.

Drop-in Centre

1. User background and satisfaction.

School Consultation

1. Teachers' assessments
2. Consultants' assessments.

Community Program

1. Survey of neighbourhood agencies.
2. Evaluations by group participants.

TABLE 6. RESEAU PARENTS NETWORKS

Sponsors

Parent Preschool Resource Centre, Ottawa
Pinecrest-Queensway Community Services Centre
Lowertown Community Services Centre (Centre de Resources de la Basse-Ville)
Co-ordinators, Ann Raney, Jack McCarthy, Renee Ouimet
Evaluators, Prof. Art Stinson, Carlton University and Lise Lavoie

Objectives

1. To begin development of a community-wide network of neighbourhood-based parent support programs.

2. To strengthen abilities of parents to deal with stress, enhance parent-child relationships, improve self-image and make better use of community resources.

3. To develop a model for relationships between a central agency and community resource centres.

Target

Parents of pre-school children in several low-income, high-density communities including francophone and anglophone parents.

Program components

1. Neighbourhood drop-in programs.

2. Outreach and program support to local neighbourhood drop-ins.

Staffing

Mostly paraprofessionals selected from target communities; program support from professional staff.

Evaluation design

Time series pre-test, post-test design.

Measures

1. Structured interviews.
2. Participant observation.
3. Staff diaries.
4. Case studies.

TABLE 7. RURAL PRIMARY PREVENTION PROJECT

Sponsor

Sudbury Algoma Hospital, Community Clinics Department
Co-ordinator, Dr. Tony Miller
Evaluators, Dr. John Lewko and Dr. Walter Schwager, Laurentian University

Objectives

1. To increase coping skills of young parents.

2. To provide structures for leisure activities for youth and improve coping skills for high-risk teens.

3. To overcome community resistance, develop community support base and reduce social stress in community.

Target

1. Parents on Manitoulin Island and Elliot Lake, including anglophone and francophone families.

2. Native parents near Espanola and along the North Shore.

3. Youth on Manitoulin Island and in Massey.

Program components

1. Parenting programs in English and French.

2. Development of Native parenting program.

3. Youth groups, peer counselling, skill development.

Staffing

Paraprofessionals, mostly selected from local communities.

Evaluation design

Pre-test, post-test design for each component; waiting list comparison group for English and French parenting programs.

Measures

1. Structured interviews and questionnaire.
2. Consumer satisfaction measures.
3. Rating of social skills development.
4. Parent interview.

APPENDIX 3: INTERPRETATION OF RESEARCH FINDINGS

Throughout this report, reference is made to certain findings being "statistically significant." This is a concept that researchers use when they are dealing with quantitative data (e.g., scores on a test of self-esteem) to decide whether the differences observed between two groups on some measure is larger than would be expected by chance.

For example, if 30 children in a classroom were administered a test of self-esteem and if the tests were later randomly divided into groups of 15 students each, one could calculate an average score for each of the two groups. It is highly unlikely that these two average scores would be identical. In fact, if we did this several more times, mixing up the tests and dividing them into two groups, we would expect to continue to see pairs of group scores that were similar to one another, but not identical. Some of the differences in group scores would be large and some would be small, but they would all be nothing more than chance variations.

However, suppose we were to compare test scores from one class with that of another class that had received special training to increase their levels of self esteem. A score indicating greater self esteem would be expected of the second group — if the training were effective. That is, we would expect to see a much larger difference in scores between these two groups than we had observed before in our random divisions of the classroom. How large does a difference have to be before the notion that it is probably "just due to chance" is dispelled? We use a test of statistical significance. This test enables a researcher to determine the probability that the difference observed between two average scores is a chance variation.

If there is a large difference between the test scores of the two groups of children — one group receiving self esteem training and the other not — the probability of this difference being attributable to a purely chance variation is low. A more reasonable explanation might be that the training had the desired effect, the evidence being the large difference observed in the scores between the two groups.

How large is a "large difference"? Researchers typically use the "five percent rule." That is, if an observed difference is so large that it would have occurred by chance only five times out of a hundred, then that difference is considered to be statistically significant. It means that we can probably reject the notion that this difference we have just observed is due to chance alone. The researcher uses this evidence to gain support for the hypothesis, or explanation, being tested. An example of such a hypothesis might be "it is possible to design a training course for children that causes an improvement in their level of self esteem." Now if the difference in the scores between the trained and the untrained group shows that the trained group does

indeed have higher scores, that is one bit of evidence to support the hypothesis. If that difference is so large as to be statistically significant (i.e., the difference might have occurred by chance, but is so large that it would have occurred by chance less than five times out of a hundred), that is a second piece of evidence that can be used to gain support for the hypothesis.

The formula for calculating whether or not a finding is statistically significant takes into account not only the sheer magnitude of differences between two means, but also the variability of the individual scores. For purposes of this report, all references to a finding being "statistically significant" means that there is a five percent chance or less of an observed difference having occurred by chance.

NON-SIGNIFICANT DIFFERENCES

It should be emphasized that just because the difference in scores observed between two groups is not large enough to be statistically significant, one cannot necessarily conclude that the program being evaluated was ineffective. Here are some very common reasons that one might fail to observe a statistically significant difference.

- The size of the group being observed may have been too small. This is, a difference between two means of ten points might be statistically significant when comparing two groups of a hundred persons each. However, since large variations in means are observed more frequently when dealing with smaller samples, the ten-point difference may be observed thirty times out of a hundred when the size of each group consists of only ten persons. In the present series of research studies, small sample sizes were common. More of the observed differences would have been statistically significant had the sample size been larger.

- Program effects of a highly positive nature might have been observed by front-line staff, but the researcher may have expected a different type of change. Program participants cannot be administered every conceivable measure of change; thus, the researcher must always take the risk that the wrong tests may be selected, and therefore, may not detect the program effects that occur.

- Many tests used to assess personality differences and behavioural change are not as precise as one would like. Thus, a training program may have an effect, but the results may show no statistical difference between two groups simply because the testing instrument was not sufficiently precise to detect the shifts that occurred.

There are many other reasons to account for lack of statistical differences, even though changes seem to have occurred in a group over time as a result of programming efforts. When researching programs for the first time, it is not unusual for the most important finding to be simply that the researcher knows what to do "next time."

QUALITATIVE FINDINGS

For the above reasons, researchers in the social sciences also make use of qualitative data. For example, programs often have particularly marked effects upon certain individuals in a manner that had not been anticipated. It is important that this be reported, even though there are no quantitative data to "back-up" the observer's judgment. In a field where quantitative measures are generally considered to be imprecise and where changes to be observed may be relatively small, the usefulness of qualitative data cannot be ignored. Such data must nonetheless be treated with extreme caution. There is a marked tendency for those who are "very close" to a program to be unduly influenced by one or two extreme cases. Also, people are generally inclined to believe that activities in which they have invested their complete effort and interest are in fact worthwhile.

Research reports prepared by the evaluators took a fairly conservative stance with respect to the use of qualitative data. That is, considerable emphasis was placed on the use of quantitative data. Interpretations of a qualitative nature were included. However, the researchers were cautious on this aspect, generally providing various arguments and supporting evidence for such interpretations. They avoided the use of unsubstantiated statements of opinion from those connected with the program.

This report reflects the outlook of the program evaluators. Primary emphasis is placed upon the use of quantitative data. Comments of a qualitative nature are included as seems appropriate.

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